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the Canadian Nurse

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MONTREAL
JANUARY 1960

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Subscription Rates: Canada & Bermuda: 6 months $1.75; one year, $3.00; two years, $5.00.
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U.S.A. & foreign: one year, $3.50; two years, $6.00.
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Make cheques and money orders payable to The Canadian Nurse.

Change of address: Four week's notice and the *old* address as well as the new are necessary.
Not responsible for Journals lost in mail due to errors in address.
Authorized as Second-Class Mail, Post Office Department, Ottawa.
Member of Canadian Circulation Audit Board.

Advertising Representatives: W. F. L. Edwards & Co., Ltd., 34 King St. E., Toronto 1, Ont.
Walter Slack, 801 Public Ledger Building, Philadelphia 6, Pa.

1522 Sherbrooke Street West, Montreal 25, Quebec

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Between Ourselves

Volume 56! It does not seem possible that it is almost five years since the golden anniversary of the founding of our *Journal* was celebrated. Month by month we are edging closer to the 60th — the diamond anniversary of publication. How should that be celebrated?

* * *

Elsewhere in this issue is the half page application form that we invite you to use to secure your own copy of the index of the material published in 1959. The copies will be available within the next few weeks.

Even though the *Journal* is published in separate issues for each of our national languages, both are combined insofar as the index is concerned. Every article that has been published in either language during 1959 is included in this bilingual reference.

Since only a limited number of copies of the index is printed, please send your application form along immediately.

* * *

An important announcement, appearing on page 74, heralds the second step in the program of translation from one language to the other that began with the first issue of *L'Infirmière Canadienne* in June, 1959. Beginning next month *all* of the professional advertisements will be published in both languages — those giving information regarding postgraduate courses in universities and hospitals as well as the numerous institutions and organizations that are seeking staff for a variety of positions.

Some of you may wonder why the *Journal* Board considered it just and right to share all of the information regarding employment or postgraduate training opportunities in obviously English language institutions with our French-speaking colleagues. The answer puts those of us who are English-speaking only to shame! Thousands of the nurses whose native language is French are completely or partially bilingual. Many of the latter long for the chance to improve their knowledge of English through association with completely English-speaking staffs and patients. How many of us whose native tongue is English would have the courage to seek work in a French hospital?

* * *

A shining example of complete bilinguality is our gracious president, Miss Alice Girard, whose New Year message appears in this issue. Despite an exceedingly heavy work-load as director of nursing at Hôpital Saint-Luc, Montreal, and principal of the school of nursing there, Miss Girard finds time and energy to shuttle back and forth to Ottawa for frequent meetings, to meet with government committees, to perform all the multifarious duties that fall to the lot of the president of an organization as busy as the Canadian Nurses' Association. We were very hesitant about adding to her tasks by our reminder of the guest editorial. We are most happy that she consented to send us all her message.

* * *

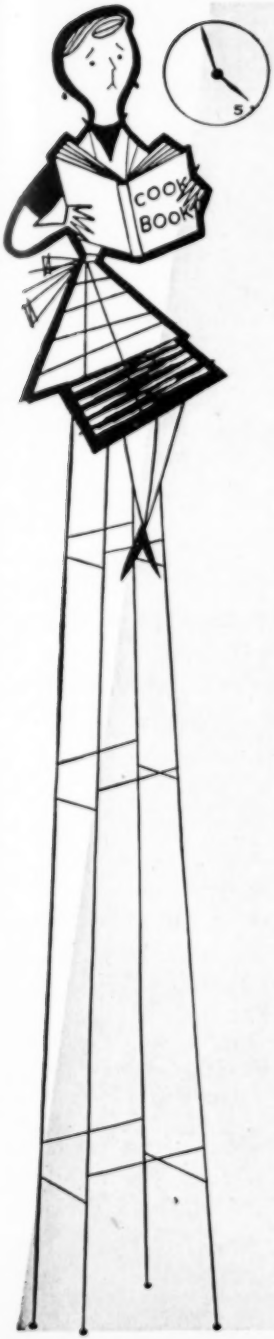
All of us have been subjected to the objective-type examinations at one time or another. "Parlor games," those who consider them much less effective than the essay-type examinations, will snort. If you feel that way about them turn to the sample questions in Dr. W. H. Lucow's article and, without referring to the correct answers, complete the test to the best of your ability. You *may* be due for a surprise!

* * *

Thousands of new patients are admitted to hospitals all over our country every day. For some it is an awesome experience, a step into the unknown that is beset with fear, even terror. Even where prepaid hospitalization plans relieve anxiety regarding expenses, there may be a haunting dread of rapidly accumulating bills for extras that will whittle away careful savings. Above all, there are all those questions that have to be answered for the person in the admitting office!

The thoughtful, kindly nurse in that department of the hospital, who welcomes the new patient with as much courtesy and friendliness as a good hostess welcomes a guest in an up-to-date hotel, can help to soothe the fears and calm the doubts, even though she is swamped by a heavy list of new admissions. As is pointed out in our brief series of articles on the work of the admitting department, that is where good public relations begin.

Without music life would be a mistake.
— Nietzsche



THIS little housewife had a problem — sweet-tooth Hubby on a sweet-free diet. (And beginning to get nervous about it.) She tried everything. Fancy salads. Bigger helpings. But Hubby's frown darkened by the day. Then one day she read in a magazine about a discovery, a new non-caloric sweetener. One that she could actually cook and bake with — in any food, at any temperature. One which gave the perfect taste of sugar — with no bitter aftertaste in ordinary use. That night there were cookies, pudding, coffee — *sweet* coffee — and a big, big smile across the table . . .

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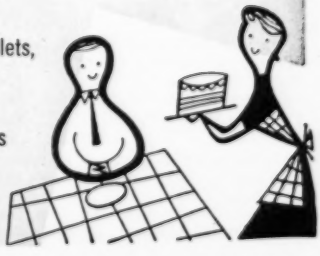

New Products

PUBLISHED THROUGH COURTESY OF *Canadian Pharmaceutical Journal* AND IN COOPERATION WITH THE PHARMACEUTICAL FIRMS.

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Indications—Systemic bacterial infections. It is particularly effective against staphylococcus, streptococcus, D. pneumoniae and E. coli.

Administration—Average adult dose is a 250 mg. tablet q.i.d. with meals and at bedtime.

Description—Altafur, brand of furaltadone, is a nitrofuran (synthetic antimicrobial, not an antibiotic or sulfonamide). Chemically it is 5-morpholinomethyl-3-(5 nitrofurfurylideneamino)-2-oxazolidinone.

Manufacturer—Eaton Laboratories, Norwich, N.Y. Canadian distributors: Austin Laboratories, 32 Baker St., Guelph, Ontario.

CATRON

Indications—Anti-depressive agent effective in mental illness, angina, and hypertension.

Administration—Must be given by mouth.

Description—One of a group of agents known as monamine oxadase inhibitors which operate by inhibiting enzymes in the body that destroy neurohormones such as serotonin and norepinephrine.

Manufacturer—Lakeside Laboratories (Canada) Ltd., 24 Wellington St. West, Toronto, Ontario.

DESITIN HC

Indications—To alleviate inflammatory and allergic symptoms and to promote healing in severe, acute and chronic inflammatory internal hemorrhoids (non-surgical), proctitis, cryptitis; inflamed postoperative scar tissue; internal anal pruritis.

Administration—1 suppository twice daily for up to six days or as required.

Description—Each suppository contains 10 mg. hydrocortisone, high grade Norwegian cod-liver oil, lanolin, zinc oxide, bismuth subgallate, balsam of peru, in a cocoa butter base.

Manufacturer—Desitin Chemical Company, Providence R.I., Canadian Distributor: Leslie A. Robb, 54 Baby Point Rd., Toronto, 9.

DIAPARENE PERIANAL CREME

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Manufacturer—Homemakers' Products (Canada) Limited, 36 Caledonia Rd., Toronto, 10.

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Description—Each tablet combines: sea salt containing the 39 analyzable trace elements that are lost in human perspiration, ascorbic acid and dextrose.

Manufacturer—Taylor Laboratories, Houston, Texas.

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Administration—Available in 5 mg. spansules and 2 mg. scored tablets. Adults: 1 spansule every 12 hours or 1 tablet 3 or 4 times daily. Children: under 6 years, ½ tablet (1 mg.) once or twice daily; 6-12 years, adult dose or 1 spansule daily or a 2 mg. tablet b.i.d.

Description—Hispril contains diphenylpyraline hydrochloride.

Manufacturer—Smith, Kline & French Laboratories, Montreal. 9.

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Description—Mephyton is Vitamin K, (2-methyl-3phytyl-1, 4-naphthoquinone).

Manufacturer—Merck, Sharp & Dohme, Division of Merck and Co. Limited, Montreal. 30.

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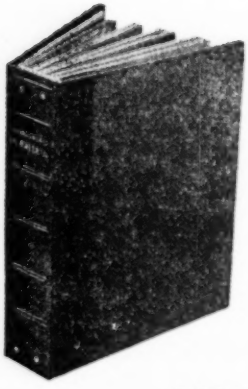
Suggestions for the course program .....



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Manufacturer—Baxter Laboratories of Canada, Ltd., Alliston, Ontario.

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Random Comments

Dear Editor:

May I say that I do not agree completely with the author of "Why Judge Them?" of the November issue. The author lays the total blame at the doorstep of the parents. This conclusion is based on the testimony of the unmarried mother. How valid then is this conclusion? It is unlikely that a young woman in this position is capable of examining herself or her parents objectively, either before or after becoming pregnant.

The author mentions the number of broken homes and unhappy homes that are not actually physically broken. If this is a reason, why are there not more unmarried mothers among the daughters of these homes? Surely there are more unhappy homes than there are unmarried mothers.

Is it not more correct to find some explanation in the fact that the unmarried mother is unable to cope with the experiences of her life in a way which is acceptable to the mores of society. Surely the therapy used in the author's homes for unmarried mothers verifies this latter point of view.

D. R., Saskatchewan

Dear Editor:

I have just read my November copy of *The Canadian Nurse* and I would like to comment in particular on the article about the unmarried mother.

The subject has been dealt with most compassionately and very understandingly. It should be required reading for parents with teenage daughters or sons! Over and over again psychologists have pointed out how necessary firm but just parental control is in the lives of children. Our girls and boys need to know where their parents stand in relation to certain moral issues so that they, too, can take a stand. The example set by the parents, the opportunity for frank discussion between mother and daughter, father and son — all help our young people in their very important business of growing up to mature happy adulthood and, eventually, parenthood.

I am called upon to do considerable student nurse counselling in my work. I most certainly intend to use this article in my discussions with the girls since I feel that it will contribute to their understanding of others and also help them personally.

E. M. H., British Columbia

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Dear Editor:

I am finding the issues of *L'Infirmière Canadienne* very interesting but I would like to see more articles related to otolaryngology and ophthalmology.

Having had a friend who had surgery performed for a detached retina, I would like to know more about this condition — its causes, the operative technique and prognosis.

L. F., Quebec

Dear Editor:

May I use this opportunity to tell you how much I appreciate *L'Infirmière Canadienne.*

It helps me to keep up with the new techniques and new drugs that appear almost daily and with which I am unfamiliar.

M-B. P., Quebec

Dear Editor:

I did not have to turn over the page to know the author of "Great Expectations," though I did so with interest to finish reading it.

May I congratulate you on a very excellent article? A few more like it should work marvels in this day and age, when this aspect of nursing appears to be among the last to be given consideration.

M. M., Quebec

Dear Editor:

I want to congratulate you on *L'Infirmière Canadienne,* which is a very instructive and interesting journal. It provides hours of profitable reading and keeps one up-to-date with the latest medical discoveries and new techniques in the various hospital departments.

Enclosed is a money order for a year's subscription and I shall certainly renew it at the end of that time. Thank you for the special rate for student nurses.

R. F., Quebec

Did you know that men such as Einstein, Max Born and Sikorsky were all refugees, who gave their adopted countries priceless knowledge and industry?

The Red Cross World, Vol. XXXIX, No. 3

The best mirror is an old friend.

— George Herbert

* * *

Love your neighbour, yet pull not down your hedge. — George Herbert

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---

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THE CANADIAN NURSE

A MONTHLY JOURNAL FOR THE NURSES OF CANADA PUBLISHED IN ENGLISH AND FRENCH BY THE CANADIAN NURSES' ASSOCIATION

74 STANLEY AVENUE, OTTAWA

VOLUME 56 NUMBER 1

MONTREAL, JANUARY 1960

Wanted: Leaders

WITH the increasing development of a social consciousness in the varied and complex problems of the nursing profession today it seems that a major concern must be the development of leaders. On a board scale, we are concerned with the changing policies and philosophy of nursing education and nursing service. We want our schools of nursing to be organized, administered and financed in such a way as to conform with modern theories of education. We want our nursing services geared to the fulfilment of the needs of society. We are anxious to determine most efficiently the functions of our various categories of professional nurses and of our nursing personnel. We wish to make clear what we expect from nursing studies and research projects and how we plan for the maximum utilization of the data we collect. When we examine these problems from all these angles, we are perhaps partly justified in thinking that what we need most may not be more nurses but more leaders.

On a smaller scale, we are confronted with the everyday problems of leadership. We must select and prepare the nurses who, through the experiences and skills that they acquire as teachers, head nurses and supervisors, will prepare for the broader tasks that today's changing order will present as tomorrow's challenge.

We often hear the complaint that

(G. Carpenter)

ALICE GIRARD

potential leaders are loath to accept positions of leadership. Have we made these positions appealing enough to induce those who show some promise of success, to want to accept the added responsibilities? Should we not start looking for potential leaders among student nurses and is it not our duty to train leaders? We never know the measure to which a person can develop leadership qualities until she has been given the opportunity to exercise this ability. We all know persons who have developed surprisingly well when placed in the right situations. Since leadership is concerned with how people can be helped to work together effectively and happily towards a common end, team work offers good situations for the young nurse to try her skills in human relationships. Studies made by the Carnegie Foundation indicate that success in leadership depends more on desirable personal qualities than on any other single factor.

The young nurse with these qualities in such a situation can often, with youth's natural vigor, energy and enthusiasm, gain what she lacks in experience, for experience is of value only if it has been of the right kind. If the young nurse offers possibilities that we must not neglect, the mature nurse on the other hand may have the surer judgment, the breadth of vision and the prestige that her accomplishments offer. She is also more apt to have better developed skills, ability and poise. Have we not all, at one time or another in our career, admired a mature leader who has influenced our behavior and inspired our life? In a study of why some leaders fail, the leading reasons were lack of appreciation of the importance of human relations, inability to cooperate with others, to delegate responsibilities and to make decisions.

Mildred E. Newton states five "I" qualities designed to help attract and develop potential leaders:

Identify the leadership characteristics.
Interpret the role of a leader.
Inspire the ambition to become a leader.
Instruct for leadership.
Initiate the climate for leadership.

To elaborate on these qualities would take too long. All are, perhaps, equally important but I believe that the last one should permeate all phases of the others. Before complaining of the lack of leaders let us look at the air that we create around us and see if it is that of a good climate in which to grow leaders.

Newton, M. E. Developing Leadership Potential. *Nursing Outlook*, July 1957.

ALICE GIRARD
President
Canadian Nurses' Association

Going to Boston in February?

The annual four-day joint sectional meeting of the American College of Surgeons will be held at the Sheraton-Plaza Hotel, Boston from February 29 through March 3. Nurses are guests of the college and as such pay no registration fee.

The preliminary program is as follows:

February 29

Morning: Panel — The Person with an Ileostomy

Afternoon: Panel discussion and demonstration — Surgical Sepsis.

March 1

Morning: Panel — Rehabilitation of the Severely Injured Patient.

Afternoon: Panel — Medical and Surgical Nursing in the Basic Curriculum.

March 2

Morning: The Burned Child: fresh burns, the convalescent patient, nursing aspects.

Afternoon: Panel — Nursing Research: Its potential Growth and Development

March 3

Morning: Panel — Comprehensive Care of Patients who have Maxillofacial Surgery and Laryngectomy.

There will be hospital tours and demonstrations for nurses Monday through Wednesday.

Three Wishes

DOROTHY M. PERCY

Remember if you can the message given to you on your graduation day. How different perhaps from these three wishes for a group of 1959 graduates.

IN the far off olden time (1926) when I was briefly associated with The Ottawa Civic, it seemed a busy enough place in all conscience. The first of the new houses in this area were creeping close to the hospital. There was, however, considerable concern lest patients' relatives and friends would find the hospital "a bit far out" on visiting days.

Now, in more senses than one, the Civic is almost in centre town. As this hospital, built in the 1920's, strives with courage, energy and vision to meet the medical and nursing needs—and demands — of the 1950's, we see an increasingly meaningful interchange between hospital and community. For example, nurses in hospital are finding themselves giving more health teaching to patients and their families. This is part of the therapy in which the nurse in hospital participates.

Conversely, the nurses in the community are doing more bedside nursing as greater numbers of patients move out earlier from hospital to their homes. This movement is bound to be accelerated. Early ambulation, self-help, rehabilitation — all of these and other factors as well are adding to clinical nursing the coloring of that which was once considered public health nursing only. The care in their own homes of increasing numbers of patients discharged earlier from hospital or prevented from going unnecessarily into hospital, is giving clinical coloring to the work of the public health nurse.

This is interesting and challenging for the hospital and the community. Among other things, it points up the interdependence of the two and the urgent need for the development and maintenance of close and better communication between them. There are important implications, too, for the education of the student nurse.

It would be fatally easy for me at this point to elaborate on the complex and baffling problems that face nursing today. Some of the problems you are familiar with; others will doubtless affect you shortly. Today is supposed to be, in a very special sense, *your Day*. For you, then, I make three wishes. I wish for you:

1. *A hard life*
2. *The courage to be "different."*
3. *Something which, for the moment, will be labelled simply "J.A."*

Now what do I mean by deliberately wishing you "a hard life?" Am I completely out of step on an occasion when, as a matter of course, the most frequently repeated wishes you will hear will be for you success and happiness? Not at all. These things are not mutually exclusive — success, happiness and hardness of life. I believe, with all my heart, that young people have a tremendous capacity for response to the present-day equivalent of "blood, sweat, toil and tears." The trouble is, that we so often offer them instead of bread, a "stone."

I repeat therefore the hope that you will have a "hard life." Please note, I am not suggesting that there should be any slackening in efforts to bring about long overdue improvements in nurses' salaries and working conditions. Such improvement is vitally urgent. What I *am* pleading for is that as young nurses you will not think exclusively in terms of *security* but rather of *how* and *where* you can make the best investment of your newly acquired professional skills, not only as nurses, but also as citizens.

Mr. Gratton O'Leary, speaking some time ago to the Rotary Club of Ottawa, characterized as frightening this

pitiful craving for the unadventured

This address was given to the 1959 graduating class of the Ottawa Civic Hospital by Miss Percy, Chief Nursing Consultant of the Department of National Health and Welfare, Ottawa, Ontario.

> life, for what is called "security;" men at 20 dreaming of 65; in youth, aspiring to a safe senility; men becoming smaller and meaner through shrinking from the duties and responsibilities of life.

In my travels across Canada in the course of my work I see nursing in many of its aspects. I catch glimpses of the needs and the breath-taking challenges there are for young people in our country. Never were the opportunities so many or so exciting for the young nurse who is alert, keen and ready to meet them head on. Don't let anyone tell you the pioneer days of Canada are over! There are still frontiers — even in the geographical sense.

The horizons are indeed unlimited. One thinks of the opportunities presented by the newer concepts of nursing care in the fields of psychiatry, rehabilitation, geriatrics, home care, etc. There is the crying need for more well-prepared teachers in schools of nursing. The changing emphases in community nursing are fascinating, too. Nursing has struck its tents and is on the march.

Nor are the opportunities limited to our own country. Canadian nurses are making a distinguished contribution in many centres abroad through the World Health Organization and Colombo Plan programs.

The word *apprenticeship* is not in very good odor in nursing education circles today. We might remind ourselves, however, that in medieval times a person was apprenticed not to a *job*, but to a *master*. Frankly, I look forward to the day when we shall have "Masters of Nursing" (not necessarily or solely in the academic sense, increasingly important and desirable as these degrees may be for a certain number of nurses) but *masters of the art of nursing*; practitioners *par excellence* of nursing in its widest and deepest sense, from whom the on-coming generations of nurses can learn much that is not contained in textbooks. Perhaps one or two of you may, after the "passport" you receive today has been stamped with various experience "visas", aspire to be that kind of practitioner of nursing. It could be rewarding not only for you, but for your patients and the doctors as well.

So much for the "hard life" that is going to make demands on everything you have to offer of skills, personality and character. What about my second wish — the courage to be different?

One of our greatest dangers today, not only in nursing but in almost every field, is that of developing into "conformists." People are afraid to be "different," of being "individuals." This is particularly tragic when we see it among young people who should be, in the constructive sense of the word, rebels. Quoting Mr. O'Leary again:

> We think in headlines, live on slogans and catch-words dreamed up for us by cocksure commentators on radio and television who have all life's answers wrapped up for us in cellophane. We are all "know-how," and no "know-why"; all facts and no knowledge, all specialization and no wisdom; all signposts and no destination.

Rather grim, isn't it? But there is a hard core of stern truth in it. It *is* hard to be an individual today, to think independently, to act independently. We move with the herd. We are vulnerable to the impact of mass communication media. "Togetherness" has become a cult. It is increasingly difficult to obtain time, quiet and privacy in which to learn "the color of one's soul."

I should like to incite you to open rebellion against the *status quo*. The problems that beset our profession need some fresh, independent thinking. Don't sit back and let the "nursing leaders" do this for you. Believe me, *they* are groping, too? Yours may be the ideas that will help cut through some of the tired clichés and inadequate compromise solutions. In whatever field of nursing you find yourself, don't be afraid to think as an individual, and to make your views known. It may be hard to be different but it is essential if we are to break out of this vicious circle of mediocrity and conformity. "Where all think alike, no one is thinking very much."

Now I suppose you are wondering about my third point — *"J.A."* There is a little old book in my bookcase of which I am very fond. Its title is "Pedagogue Pie." It was published in England in 1936 (now out of print, alas!) and was written by D. F. P.

Hiley, then about to retire after 40 years as headmistress in a girls' school.

The author must have been a salty old lady and although her terse, pithy, philosophical reflections have to do with teachers and teaching, much of what she has to say applies equally well to nurses and nursing. For instance, she makes this strong plea for the development of interests outside one's work:

> Though one should give one's whole self to one's profession it is just the superabundance of personality that will not be absorbed, but slops over into other things that is going to make one's work vital and productive.

This seems to me an important word for our day when we are all in every walk of life, caught in traps of over-organization and over-specialization. Do make sure, as you launch out into your professional life, that you invest in those values that, strictly speaking, lie outside nursing but which, in a very special sense, will increase your stature as a nurse.

I would wish for you that you never lose your desire to learn something new (or, it may be, something old); that you keep your sense of curiosity sharp; that, if you think you haven't had much time up to now to read widely, you will set about discovering the delights and consolations of books.

Nurses, you know, (at least we older ones) are sometimes suspected of being narrow in our interests and, it must be confessed with sorrow, even of being a bit tedious, earnest and downright dull! Anything that will jolt you out of your nice comfortable rut, that will broaden your horizons, will help make it unlikely that you will ever be labelled "dull."

I think here, too, of music, painting, bowling, dramatics, swimming, square dancing, gardening, cycling, bird watching, hobbies of various sorts; work with church groups, community activities — oh, just dozens of things. The main thing is that whatever you do should be different, in degree at least, from your everyday work. Most important, it should be something *you* like doing because it's fun, not because you (or anyone else) thinks you should do it.

You see, outside interests will help to make you a more vital, more interesting, more understanding person: in short, a better nurse, well equipped to give generously of yourself to a troubled world hungry for friendly concern. Hear our retired headmistress again:

> What really permanently impresses one is the increasing richness of life . . . Do let the free part of your personality flap in the wind. Keep your sense of wonder fresh and your interests active, especially human, artistic, spiritual interests.

Oh yes, what is *"J.A."?* This is an abbreviation I use to designate something that the headmistress feels no professional woman should be without — a touch of what she calls "joyous assishness" — the art of being, every once in a while, and for no particular reason, just what it says — "a joyous ass"!

How about a "spot of J.A." — guaranteed to have definite value as a head shrinker, and as an allround, sure-fire antidote for the "poison" of taking oneself or one's work too seriously? Just a mite crazy, you understand. As the headmistress puts it: "There is something to be said for an agreable touch of lunacy. Madness is so vitalizing." Not a bad prescription, taken in small doses with a nice discrimination, whenever you find yourself becoming tense, irritated and frustrated with this exasperating business of being a nurse.

Now one last word which, I think, sums it all up and apart from which nothing we are or do has any real or lasting significance. Dr. Karl Menninger, one of the world's outstanding figures in the mental health field says: "Love is the key to the successful treatment of the mentally ill patient." He might have said: "Love is the key to the successful treatment of *any patient,* or indeed of any person." This we must learn for it says it all.

It would seem of utmost importance that all of us understand that, when we say this, we are expressing our belief in something that is more than a pious platitude, totally unrelated to the stark requirements of professional competence. In the heartbreaking pressures exerted today on hospitals there is a real danger of the personal factor being overlooked in pursuit of organization. Faced by the need for ever-

expanding facilities and mounting costs, it is inevitable and understandable that hospital authorities be ceaselessly concerned with efficient operation. We need to remind ourselves from time to time of the reason for the existence of a hospital — that the services rendered are *for a person*, given *to a person, by a person*. This philosophy must permeate the attitudes and behavior of all who serve in the health field. It will affect especially the one who has the closest relationship to the patient, the nurse.

You who are graduating are well equipped for what you have to do. You have much to offer your patients in the way of skills and techniques. It is vital for the safety, comfort and ultimate recovery of your patients that you understand the purpose and nature of these and that you perform them well. But you and I know that, while essential, these are not the whole of nursing. In spite of scientific discoveries and technical advances in medicine (rather, perhaps, because of them) your patients, who are human, are still very much in need of understanding, sympathy, and compassion.

Many patients, I think you will find, are impressed not so much by what you *do* for them or *with* them, but by what you are *to* them. It is what you give of yourself that is of therapeutic value. So, in this "helping" profession you have chosen — this "giving" profession, if you will — make sure that in addition to everything else you give your patients, you give them yourself, too. As one of the older poets reminds us, "The gift without the giver is bare."

This final thought I want to leave with you has been well said recently. I quote from an editorial written in tribute to the late Dr. William Cone, of the Montreal Neurological Institute.

> To all those who came to him wondering and worrying, he gave the fullness of his hope, and in the hopeless times, stood with them in their sorrow.

In the Good Old Days

(The Canadian Nurse — JANUARY, 1920)

Possibilities of Newfoundland — Lord Morris said, not long ago, that there are sufficient fish on the Newfoundland banks and along the Newfoundland and Labrador shores to feed the whole of the British Empire. It is the second largest producer of iron in the British Empire, England being first. There is enough to supply the needs of the world for the next hundred years.

* * *

The Mothers' Memorial — A silver cross, hung from a purple ribbon, is to be given to any mother in Canada who lost a son in the war. Major-General Mewburn, Minister of Militia, is the authority for the statement.

* * *

The Prince a Canadian — In one of his after-dinner speeches in New York, the Prince of Wales said: "I have become a rancher and a farmer in a small way by buying a ranch in Alberta. This makes me feel quite a Westerner; for the young, free, democratic spirit of the West appeals to me enormously. I had a wonderful time in Canada, and Canadians quite spoiled me by the kindness and hospitality which they showed me throughout my three months' tour across the Dominion and back." In another speech he said that he came to the United States not only as an Englishman, but as a Canadian, across a border for three thousand miles undefended by a fort.

* * *

Belated News for Eskimos — The Eskimos living near Cumberland Bay, on the Arctic Coast, had had no visitors from the outside world since 1917. When the crew of a Norwegian steamer told them of the end of the war, and the Allied victory, they were greatly excited. They celebrated with singing and dancing, to the music of a melodeon. They were strongly pro-Ally, as they had been badly treated by a German crew that visited them before the war. They were skeptical about the submarines, being unable to understand how a vessel could sink another vessel when itself under water.

It is true that liberty is precious — so precious that it must be rationed. — LENIN

Test Construction in Nursing Education

WILLIAM H. LUCOW, PH.D.

If you have had difficulty in measuring the achievements of your nursing students and can identify your problems, the solutions may reveal themselves in this study of the construction and use of objective tests.

PRESENTED below are the ingredients of a four-session course in test construction given to teachers from Manitoba schools of nursing at their Institute for Instructors held June 15-19, 1959 in Winnipeg.

Session One started with the instructor's declaration that the invitation "tickled him to death" like the grasshopper who swallowed a caterpillar.

The purpose of the gathering was to gain facility in constructing and using objective tests with which to measure the achievement of nursing students. The virtues of objective tests, validity and reliability, were briefly discussed, and the meeting went on to the practical consideration of a sample test based on one of their offerings, *Fundamentals of Nursing*. As an introduction, the test was taken by the teachers themselves, who were then in a better position to follow the argument on how validity and reliability might be incorporated. The test is given in full on page .

The first step in test construction is the drawing up of a *table of specifications*. This should be done before the first lecture is given. The syllabus or program of studies together with the textbook are studied by the instructor, who then draws up a plan of topics weighted in importance by percentages. The proportions of marks for each topic in the final examination correspond roughly to those planned. The table of specifications, used as the basis for the sample test in the fundamentals of nursing appears on page .

Each topic in the table of specifications is identified by a key letter, to be used on 3 x 5 cards when the individual items are composed. This should be done daily, after each lecture, so that the final test may have content and curricular validity. By the end of the course the file of items should be large enough to afford an adequate selection.

Validity may be further incorporated by dropping or altering items that prove ineffective in the first administration.

Session Two was used to analyze hypothetical answers to the test. (The instructor did not use the responses by the teachers in the audience because he felt sure all items were answered correctly, and there would be nothing to analyze.) Mimeographed copies of the hypothetical answer sheets were distributed, and all teachers present could proceed individually with the tabulation and analysis of scores. The Tabulation Sheet is shown on page 32. An "x" indicates a correct response, and an "o" indicates an incorrect response.

Analysis of the items was directed toward two aspects of validity: the index of difficulty and the index of discrimination. The difficulty of an item is defined as the percentage of correct responses. Thus, a high index of 90% indicates an easy item, while a low index indicates a difficult one. Items correctly answered by all can-

WM. H. LUCOW

Dr. Lucow is in the Faculty of Education, University of Manitoba.

didates must be eliminated. Similarly, items missed by all should be thrown out. A good working range is from difficulty indexes of 30% to 70%, with more of them closer to 50% than far from it. Items 6, 27, 28, and 13 would obviously be thrown out on this score.

The index of discrimination indicates whether the top students did better on an item than did the bottom students. In order to determine this index, the pupils are listed in order of merit, as on the tabulation sheet, and the top half is compared with the bottom half (or top third with bottom third). Item 14, on which more poor students did better than the good students, is an example of reverse discrimination. Such an item should be dropped when the test is revised.

The details of test construction and analysis of results may be found in most of the references listed at the end of this article.

Session Three was concerned with elementary statistical notions of measures of central tendency and dispersion of marks. This led to a discussion of the normal curve and the awarding of marks on the basis of standard scores rather than on raw scores.

Session Four continued the matter of marks and grades with consideration of a special problem that had arisen in practice.

Suppose an instructor of nursing students realized the unreliability of raw scores and proceeded to give letter grades, A, B, C, D, and E in the course. For final record purposes, however, the marks must be stated in numbers out of 100. The problem was: *How might letter grades be converted into number scores?*

These conditions had to be met in solving the problem:

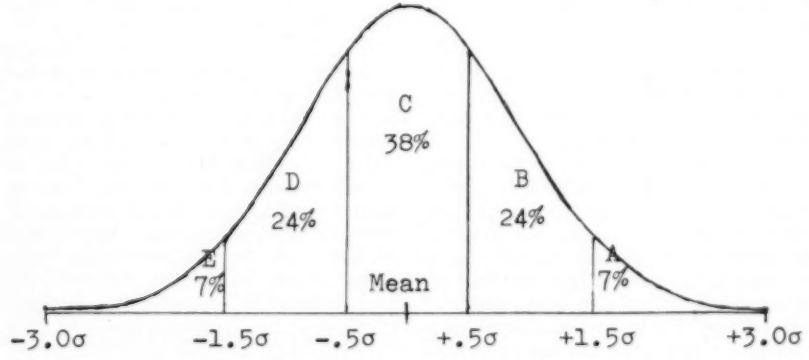
1. The pass mark was 60, so an "E" would have to be below 60.
2. The distribution of scores would be assumed to be normal.
3. The grade "C" would extend half a standard deviation on either side of the mean, and the other letter grades would be one standard deviation wide proceeding from "C" as in the diagram below.
4. The mark of 100 would be at the position three standard deviations from the mean.

The following formula was derived to fulfill the foregoing conditions:

$$L = \frac{80}{9} \quad \frac{X-M}{\sigma} \quad \pm \frac{220}{3}$$

where L is a standard score satisfying the conditions, X is the numerical raw score of a candidate, M is the mean of the group writing the examination, and σ is the standard deviation of the group.

The information in this formula could be used to solve the original problem of converting letter grades into numerical scores. Using the boundaries set by the conditions above,



THE NORMAL CURVE

A five-letter marking system would have the indicated percentage of students getting each grade.

the practical limits turn out to be:

A = 87 to 100
B = 78 to 86
C = 70 to 77
D = 60 to 69
E = below 60

Some subjective judgments would have to be made in deciding whether a mark was a high A, a middle A, or a low A, etc.

The last session ended with a discussion of essay-type questions and how they might be made more reliable.

Table of Specifications

Fundamentals of Nursing

(Based on Harmer and Henderson, *Textbook of the Principles and Practice of Nursing*, Fifth Edition, Macmillan, 1955)

	TOPIC	*KEY LETTER*	*PER CENT*
I.	*Place of Nursing in Health Service*	P	5%
	1. Purpose 2. Relationships (with others concerned) 3. Functions 4. Preparation		
II.	*Ministration of Nursing Care*	NC	30%
	1. Nurse uses her ministration as a means of knowing the patient as a person. 2. Through her ministrations, the nurse attempts to meet the physical, psychological and spiritual needs of the patient in order of relative importance to him. 3. During the ministrations, the nurse: Encourages the patient to care for himself by such means as: placement of articles, special equipment convenience of arrangement, written directions. Helps the patient to accept care necessarily given by others and to seek help when appropriate. Uses her ministrations for teaching those facts and procedures, purposes and rational of his therapy which the patient can use in meeting and solving problems of rehabilitative self-care. 4. Nurse uses the ministrations to seek evidence that the necessary modifications in the activities of daily living, such as: eating, resting, exercising, eliminating, are directed toward rehabilitation. 5. When patient's concerns of a medical nature occur or persist, the nurse encourages him to discuss them with the physician, or, if he is unable to, the nurse herself seeks medical resources for him.		
III.	*Observation*	O	20%
	1. Nurse notes patient's characteristic physical, intellectual, emotional and social behavior to situations such as: placid, tense, compliant, aggressive, withdrawn, out-going, optimistic, pessimistic, euphoric, inconsistent, garrulous, quiet, social reasoning, opinionated, sad, happy, constructive, negativistic, thoughtful, gullible; alarmist, realistic, breadth of interests, attention span. 2. Nurse notes patient's response to stress, such as: anxiety, hostility, aggression, withdrawal, over-alertness, over-talkativeness, perspiration, tremor, flushing, ill-at-ease.		

3. Nurse notes patient's individual responses to therapeutic measures in their relationship to his characteristic behavior.
4. Nurse notes the relationship of the patient's behavior in the activities of daily living, such as: self-regulated exercises, sleep habits, food habits, rest habits; to the health teaching he receives from the nurse, and to his expressed attitudes toward life.

IV. *Teaching* T 25%

1. In planning health teaching with the patient the nurse seeks verbal expression of the patient's concept of his condition and its management, as well as an expression of his readiness and motivation to learn self-care.
2. Whenever possible, the nurse includes members of the patient's home setting in her teaching of home care.
3. Before presenting information, the nurse seeks evidence of the patient's ability to carry out self-care, or of his knowledge of what changes in his condition to watch for, such as signs of progress or of regression; or of his ability to observe and to use his ability to observe, and to use his reactions to therapy as a means of regulating his care with safety. She then corrects misinterpretations, presents additional information, and reinterprets with him.
4. Nurse seeks evidence that her teaching has increased the patient's awareness of his health problems, his capacity, and limitations, to the point that the patient understands what follow-up is desirable and where to seek it.
5. Nurse permits the patient to make his own decisions, or collaborates with him when they share in making plans which affect him. Nurse helps the patient to solve his problems by encouraging him to express the first steps that he sees toward a solution and reviews these with him before adding factors or suggesting alternatives for his consideration. When patients with similar clinical conditions discuss the problems they have in common, the nurse guides the group in solving problems of self-care.

V. *Communication* C 20%

1. Nurse in authority has some direct communication with the patient and is obtainable if he requests her.
2. Nurse gives evidence, through statements and gestures, of consistent acceptance of the patient, without approval or disapproval.
3. Nurse permits the patient to set the direction of discussion about himself. For the most part, the nurse keeps the conversations patient-centered. Nurse identifies and keeps the concerns expressed by the patient in focus as long as he discusses them. Nurse identifies and seeks to clarify with the patient what meaning his illness has for him, such as: pain, fear, mutilation, recurrence, recovery, death; his relationships, such as: family, friends, doctor; and his life settings, such as: home, work, social, spiritual.
4. Nurse clarifies the patient's questions with him and tests his meaning of the terms he uses before answering him. Nurse tests the

patient's understanding of the terms she uses and the explanation she gives him.

5. When patient's concerns of a medical, spiritual or emotional nature recur or persist, the nurse encourages him to discuss them with the appropriate person of authority, or, if he is unable to, the nurse herself seeks the appropriate authority for him.
6. Nurse reflects the patient's feelings without any interpretation of them. In reassuring the patient, the nurse isolates or seeks to to have the patient express the hopeful facts that he sees and reviews these with him before adding other hopeful truths.

An Objective Test on Fundamentals of Nursing
Experimental Edition

(Based on Harmer and Henderson, *Textbook of the Principles and Practice of Nursing*, Fifth Edition, Macmillan, 1955)

Section One

Instructions: Use *T* for *true* and *F* for *false* in answering the following statements.

Record your answers on the answer slip provided. Do *not* write on this paper.

Example: Disease is an abnormal state of the body. T

Etiology refers to the treatment of disease. F

1. Likes and dislikes of food by the patient must be ignored while he is in hospital.
2. A nurse must be impersonal when referring to a patient: she should say, "the cardiac in Bed 2" rather than the name of the patient.
3. Deep-seated emotional stress may interfere with the appetite of the patient.
4. Occupation and economic status of the patient must not affect the kind of care given by the nurse.
5. It is appropriate and desirable under some circumstances to do things for patients that they are entirely able to do for themselves.
6. In pediatric service, a dose of T.L.C. may be given without a doctor's prescription.
7. Constipation is more crucial than kidney failure.
8. Play therapy has a meaning for the nurse that is different from its meaning for the psychologist.
9. The most difficult phase of medical practice is diagnosis.
10. The introvert is often elated and euphoric.

Section Two

Instructions: Complete the following statements on your answer slip.

Example: The capital of Manitoba is ..... Winnipeg

11. Normal body temperature on the centigrade scale is ..... .
12. Meat should not be served on Friday to a patient whose religion is ..... .
13. The collection of all information about a patient is known as ..... .
14. A state of unconsciousness from which the patient cannot be aroused is reported as ..... .
15. Inactive exercise in the form of massage is referred to as ..... .
16. Symptoms that cannot objectively be observed by the nurse, such as pain or itching, are classed as ..... .
17. Activity with no serious motive or material gain is known as ..... .
18. Conversation and interest of the nurse is, for the patient, a psychological ..... .

19. Assistance to a mother during and following delivery is one of the phases of nursing referred to as .....

20. A psychotic who alternates between extremes of moods is classed as .....

Section Three

Instructions: Put the letter representing the best answer on your answer slip.

Example: The nurse's greatest responsibility is toward

(a) doctor
(b) patient
(c) hospital
(d) supervisor

answer: (b)

21. Restoration of patient to optimum independence is referred to as

(a) rehabilitation
(b) recuperation
(c) revival
(d) a miracle

22. The gynic shape is

(a) fat
(b) feminine
(c) tonic
(d) tall

23. The "seven danger signals of cancer" taught by the Canadian Cancer Society includes

(a) discharge from your job
(b) persistent hoarseness or cough
(c) any change in a sore
(d) persistent constipation or difficulty in elimination

24. In the matter of elimination, the nurse is responsible for

(a) diagnosis of stool
(b) treatment of metabolism
(c) analysis of urine
(d) facilities and privacy

25. The ultimate aim of psychotherapy is

(a) shock treatment to precede lobotomy
(b) mental deficiency
(c) to bring about self-treatment
(d) to bring the person into satisfactory relationships with others

26. The best guide in selecting occupation and recreation for an individual is

(a) mental age
(b) chronological age
(c) height
(d) weight

27. Rehabilitation begins with

(a) diagnosis

(b) treatment

(c) psychosis

(d) remuneration

28. Probably the most effective method of teaching a patient to look after himself is by

(a) lecture and presentation

(b) supervision and demonstration

(c) example and discussion

(d) written instructions

29. An exuberant, optimistic, talkative person might be described as

(a) hypoactive

(b) hypodermic

(c) hyperactive

(d) hyperglycemic

30. The main purpose of a nurse

(a) is to cooperate with doctors

(b) remains unchanged throughout history

(c) is to achieve a healthy citizenry

(d) is to make the patient feel he can depend on her

Section Four

Instructions: Write the letter before the words in Column B that best match the words in Column A. Write only on your answer slip.

Example:	*Column A*	*Column B*	*Answers*
	1. nurse	(a) chemical	
	2. patient	(b) teacher	
		(c) pupil	1. (b)
		(d) emotion	2. (c)

Now do the following:

Column A	*Column B*
31. nystagmus	(a) twitches and tics
32. aphasia	(b) difficult breathing
33. fabrication	(c) abnormal eye movements
34. photophobia	(d) fear of photographers
35. cyanosis	(e) inadequate oxygenation of blood
	(f) hatred for cameras
	(g) whispering
	(h) flight of ideas
	(i) needle-work
	(j) lying
	(k) inability to arrange words

(l) abnormal sense of smell
(m) occupational therapy
(n) sensitiveness to moderate light
(o) temporary suspension of breathing

Now do the following:

36. No substitute for this in actual nursing
37. Estimate of patient's needs is based on this
38. An example of a misleading symptom
39. Exclusively the doctor's responsibility
40. Symptoms may be exaggerated by this

(a) hunger
(b) intelligence
(c) cough
(d) hypodermic
(e) interest in medicine
(f) shyness
(g) experience
(h) speed
(i) patient's request
(j) observation
(k) printed chart
(l) hypothesis
(m) patient's imagination
(n) prognosis
(o) treatment

Section Five

Instructions: In this section you must choose all the correct alternatives and omit all the incorrect ones. There may be one, two, three, or all four correct.

Tell the whole truth and nothing but the truth.

Example: Three times five is more than

(a) 5
(b) 10
(c) 15
(d) 20 answer: (a), (b)

41. Nutritional diseases include

(a) puberty
(b) scurvy
(c) beriberi
(d) rickets

42. Rehabilitation is viewed as a restoration of optimum usefulness for

(a) certain categories of handicapped persons
(b) only those who ask for it
(c) only those who pay for it
(d) everyone as part of their comprehensive care

43. Return to normal eating habits may be encouraged

(a) as soon as the patient is able to be up for part of the day

(b) by surprising the patient with visitors during meal time

(c) by having patients eat in groups

(d) by having the patient sit up to eat

44. "Plan of care" for the patient refers to

(a) the doctor's schedule of visits

(b) the distribution of parcels in under priviledged countries

(c) modification of the patient's manner of living

(d) instructions from a textbook

45. Fundamental needs in sick and well persons include

(a) to feel useful

(b) to eliminate daily

(c) to be loved

(d) to be approved of

46. Feelings or emotions are expressed in such questions as

(a) May I have some water?

(b) Isn't the doctor coming soon?

(c) What day is this?

(d) Do you think I'll get well?

47. The nurse should teach a diabetic patient

(a) how to administer insulin himself

(b) ways of avoiding insulin

(c) how to make insulin himself

(d) how to test urine himself

48. When a physician asks a nurse to teach a pregnant woman how to treat varicose veins, it is professionally correct for the nurse to ask for discussion on

(a) diagnosis

(b) symptoms

(c) treatment

(d) prognosis

49. Valuable pre-training experience for a nurse would be

(a) baby sitting

(b) assistant at summer camp for children

(c) psychiatric treatment following amputation

(d) living with a neurotic relative

50. "Professional nurse" power may be spread by

(a) using attendants and aides for simple cases

(b) having the nurse supervise the care of all patients with a team of helpers, the professional nurse doing only the more complex work

(c) limiting her activities to nursing care

(d) intensive training

Tabulation Sheet

(Hypothetical Scores)

NAME	ITEM 1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	Total
Student No. 1	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	49
Student No. 2	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	47
Student No. 3	o	×	o	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	o	×	×	×	o	×	×	×	×	×	×	×	×	44
Student No. 4	×	×	o	×	o	×	×	×	o	×	×	×	o	o	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	×	×	×	×	×	43
Student No. 5	×	×	×	×	o	×	o	×	×	×	o	×	×	o	×	×	o	×	×	×	o	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	43
Student No. 6	×	o	×	o	×	×	×	o	×	×	×	o	×	o	×	o	×	×	×	o	×	×	×	o	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	×	41
Student No. 7	×	×	×	×	×	×	×	×	×	o	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	o	×	×	o	×	×	×	o	×	×	×	o	×	×	×	×	×	×	×	o	o	40
Student No. 8	×	×	×	×	×	×	×	×	×	×	o	×	×	o	o	×	×	o	o	×	×	×	o	×	×	×	×	o	×	×	o	×	×	o	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	40
Student No. 9	×	×	×	×	×	×	o	×	×	o	×	×	×	o	×	×	×	×	×	×	×	o	×	×	×	o	×	o	×	×	×	×	×	×	o	o	×	×	o	o	×	×	×	×	×	×	×	×	×	×	40
Student No. 10	×	×	×	×	×	×	×	×	×	×	×	×	×	o	×	×	o	×	×	×	×	×	o	×	o	×	×	o	×	×	×	o	×	×	×	×	×	×	×	×	o	×	×	o	×	×	×	o	×	×	40
Student No. 11	o	×	o	×	o	×	×	×	o	o	×	o	×	×	o	o	×	×	×	×	o	×	o	×	×	×	×	×	o	o	×	×	×	×	×	×	o	×	×	×	×	×	×	×	×	×	×	×	×	×	37
Student No. 12	×	o	×	o	o	o	×	×	o	×	o	×	o	×	o	o	×	o	×	×	o	×	×	×	×	o	×	×	o	×	×	o	×	×	×	×	×	×	×	×	o	×	o	×	×	×	×	×	×	×	35
Student No. 13	×	o	×	o	×	×	×	×	o	×	o	×	o	×	×	o	×	×	×	×	o	×	×	×	×	o	×	×	o	×	×	o	×	×	o	×	o	×	×	×	o	×	o	×	×	×	×	o	o	o	31
Student No. 14	o	o	o	×	o	×	×	×	o	×	o	×	o	×	o	×	o	×	o	×	o	×	×	o	o	×	o	×	o	×	o	×	×	o	o	×	×	×	o	×	×	×	×	×	o	×	×	×	×	×	29
Student No. 15	o	o	×	o	o	×	o	o	o	o	o	o	×	×	o	×	×	×	o	o	o	o	×	o	o	o	×	o	o	×	×	o	×	o	×	o	×	×	×	×	×	o	o	×	×	×	×	o	o	×	22
Student No. 16	o	o	×	o	o	×	×	o	o	×	o	×	o	×	×	o	o	o	×	×	o	o	o	×	o	o	×	o	o	o	o	×	o	×	o	o	×	o	×	o	×	×	o	×	o	×	×	×	×	o	20

x = correct

o = wrong

KEY

1. *F*	26. *a*
2. *F*	27. *b*
3. *T*	28. *c*
4. *F*	29. *c*
5. *T*	30. *c*
6. *T*	31. *c*
7. *F*	32. *k*
8. *T*	33. *j*
9. *T*	34. *n*
10. *F*	35. *e*
11. *37°*	36. *g*
12. *Cath.*	37. *j*
13. *case study*	38. *c*
14. *coma*	39. *n*
15. *passive*	40. *m*
16. *subj've*	41. *bcd*
17. *play*	42. *ad*
18. *need*	43. *acd*
19. *obstetrical*	44. *c*
20. *manic*	45. *acd*
21. *a*	46. *bd*
22. *b*	47. *ad*
23. *b*	48. *abcd*
24. *d*	49. *abd*
25. *d*	50. *abc*

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[1]The table of specifications is largely the work of Professor Margaret E. Hart, Director of Nursing Education at the University of Manitoba, whose generous cooperation is greatly appreciated by the writer.

The simple act of blowing out a book match has now become a medical test. It is used to measure the seriousness of airway obstruction in such pulmonary diseases as asthma or emphysema.

Wheezing and prolonged expiration — the usual bedside signs of airway obstruction — do not give the necessary information to evaluate respiratory function. It is usually evaluated by two rather complicated tests requiring the use of mechanical devices, which cannot always be brought to a bedside.

The match test was devised as a simple bedside means for checking airway obstruction. If a patient is unable to blow out a match held six inches from his mouth, it is a sign that he should undergo the more specific complicated tests.

— *Journal* of the American Medical Association

* * *

The diversity of physical arguments and opinions embraces all sorts of methods.

— MONTAIGNE

* * *

There's not the least thing can be said or done, but people will talk and find fault.

— CERVANTES

* * *

A service beyond all recompense weighs so heavy that it almost gives offense.

— CORNEILLE

In the Admitting Office

MARC TARDIF, M.D.

The role of the admitting office seems obvious enough, but do you know what functions it performs? How it should be set up? Who should be in charge and why?

THE admitting office is a strategic point in the hospital — it might be called the nerve centre. Since its chief function is the admission of patients, it should be located near the main entrance of the hospital, preferably on the first floor and providing easy access to doctors, nurses and other personnel and most certainly for the patient.

The space required will depend on the bed capacity of the hospital and the type of patient care offered. At the very least there must be a waiting room and a private office. The general appearance of this department is important. We should not forget that this is where the patient receives his first impression of the hospital. A pleasant atmosphere and absolute cleanliness are a necessity.

The Personnel

This is composed of the person in charge and the staff. It is preferable to appoint a nurse as head of this department since her professional preparation fits her better than anyone else for this work. She is familiar with medical terminology and doctors' orders. She will be able to grasp the provisional diagnosis which is given by telephone very easily. Her very presence tends to soothe the apprehensive patient. The remainder of the staff is made up of investigators, bookkeepers, telephone girls, and so forth. To this could be added one or more orderlies or commissionaires whose duty it would be to take the patients to their wards.

Need one say that certain very definite qualities in the head of the department and other personnel are prerequisite — sound judgment, a sense of responsibility, patience in abundance and unflagging courtesy.

Dr. Tardif is the assistant medical director at Notre Dame Hospital, Montreal.

The Functions

These may be divided into five main categories:

1. Reservations for admission
2. Admission of patients
3. Discharge arrangements
4. Procedure in case of death
5. Transfer of hospitalized patients

Reservations

The admitting office, in some hospitals, may handle requests for consultations and a complexity of other duties besides. This brief listing of some of the tasks entrusted to it, help us to see the breadth and diversity of the work to be done.

Let us consider each one of these functions in more detail. In the first place reservations may be divided into three groups — routine, public assistance and emergency. Prior to the patient's arrival at the hospital, his doctor will have made the preliminary arrangements that ensure a bed reservation. The patient's name is put on the waiting list along with his provisional diagnosis and the type of accommodation desired. This is the *routine reservation.*

Those people who will require public assistance to finance their hospitalization, if they are not medical emergencies are seen either in the outpatient clinic or by a staff doctor. Then their names are placed on a waiting list until the department controlling public assistance funds accepts the responsibility for their hospital expenses. *If the patient's condition warrants immediate hospitalization,* regardless of his financial status, the admitting office will request authorization from the medical director for priority and the patient will be admitted immediately or with the shortest possible delay.

If admission is not urgent, the name of the prospective patient, the provisional diagnosis and the name of the attending doctor are added to the waiting list. Requests for reservations are then filled in order of asking. The admitting officer forwards a letter to the patient informing him that his doctor has reserved a bed for him and enclosing a form to be filled out which will allow the patient to speed up the process of providing information concerning his identity, employment and financial means when he finally arrives at the hospital.

A problem arises in connection with priority of admission. This is the question of social emergencies. For example: A mother must come into hospital. She can find someone to stay with her children at a specific date. Although her condition is not of an emergency nature, a request is placed with the medical director for approval of it.

The number of admissions is, of course, governed by the number of beds available. When a bed is freed through discharge, the head nurse notifies the admitting office. The waiting list is checked and the next patient is notified according to the type of accommodation desired: male or female, private or semiprivate, financial status and even the service. Sometimes a certain number of beds are allotted to a specific service and only a patient on that service is to occupy one of these beds. However, the hospital beds belong to the hospital, not to the chief of a service or to a specific doctor. The medical director can authorize admission to a service other than the one which will prescribe treatment, if circumstances require it.

It has sometimes happened that a patient has had his discharge written, the admitting office has been notified and the next patient on the waiting list has been advised to report to the hospital whereupon, for some reason, the former decides that he can not leave. This may be the situation presented by an out-of-town patient, brought to hospital by ambulance in his night clothes, given his discharge late in the day and whose relatives cannot be contacted to bring him his clothes. So there you are with two patients and only one bed.

On the other hand, it may be a woman who has been discharged but, of her own accord, decides late in the afternoon that she really is not well enough to go home. In the meantime the new occupant for her bed has arrived. The former patient is not discharged and an average of two or three hours must be allowed before another room can be prepared for the new patient.

These details may seem quite amusing at first but they are everyday occurrences in the admitting office of a big hospital. Often such situations are very irritating. They require a long series of telephone calls in an attempt to find a more or less satisfying solution to these problems.

Admission

The second function of this department has to do with the actual admission of the patient. On his arrival, the patient is identified and a multiplicate admission form is filled out. One copy is sent to the addressograph room to have a master plate made; another copy is sent to the accounts office. Copies are also sent to the records department and the information desk.

When these formalities have been completed, an orderly takes the patient to the particular floor or ward and delivers the admission slip to the head nurse.

One thankless job in the admitting office is accepting the flood of telephone calls directed towards it from every corner of the hospital and from outside as well. There is the anxious patient inquiring if his doctor has *really* put his name on the waiting list: "My doctor told me that I could soon go into hospital and that was three weeks ago!" Most of the time these complaints are made politely. Unfortunately there are times when the language is coarse and even insulting to the person who answers. The staff must often use great restraint in avoiding the temptation to reprimand the ill-bred and badly informed caller. They have to remind themselves that they are talking to individuals soured by illness.

Discharge

The third function is closely allied

to the second. When the doctor, the resident or the intern has discharged a patient, the head nurse advises the admitting and the accounts office. The addressograph plate is sent down to the admitting office and the discharge procedure is a simple one after the accounts office has given its approval.

Procedure at Death

Unfortunately not all patients can be cured and so the admitting office must have some procedure to follow in the event of a death. As soon as the doctor has certified a death, the admitting office is notified and the chart is sent down. There the final diagnosis is entered after consultation with the attending doctor and the cause of death is recorded on the death certificate. The body is removed to the morgue following preparation by the ward personnel. If the death is an unexpected one and members of the family have not been present, they must be notified either by the nurses on the ward or some other designated person. When the official certificate for demography has been filled out, the chart goes to the medical director and the cause of death is entered in a special file. If there is any doubt as to the final diagnosis or cause of death, or if there is something of scientific significance in the circumstances leading to death, the attending doctor or his intern will ask for an autopsy. In some instances, it falls to the lot of the admitting office to get in touch with the next of kin and request written permission for an autopsy. It is a difficult task to have to make such a request from people who are upset by the news of the death of a loved one. We must use tact, understanding and sympathy in our choice of words. The family are overcome by grief and the idea of an autopsy may seem both useless and repulsive. As soon as the autopsy has been completed, the funeral director is notified.

Sometimes when death occurs within 24 hours of hospitalization or following an accident, the law requires that the coroner perform the autopsy. However if the cause of death is obvious, the coroner may dispense with it.

Transferring a Patient

A patient may, for reasons of economy, request transfer from his initial type of accommodation. Sometimes the accounts office may request the transfer because the patient is unable to pay his bills or it may be a ruling of the Medical Board that, in the case of infection or of severe psychosis, the patient must be moved to an isolation room. The attending doctor will ask for the transfer or the head of the accounts office may suggest it to the doctor. This change is noted on the chart and the admitting office is also notified. Often difficulties arise through the lack of isolation rooms or other accommodation desired for transfer purposes. The admitting office has to juggle the bed list and try to find a solution to this problem.

Other Functions

Finally, the admitting office may also be on the receiving end of requests for consultation with another service or another doctor. As the requests for consultation come in, they must be stamped, date and time of their arrival noted, and then they are distributed to the services or persons concerned.

This brief description of the functions of the admitting office, although somewhat incomplete, will give some idea of the scope of work. The responsibilities and the demands of the work make it anything but a sinecure. There is considerable detail and the slightest error must be avoided. The calm of routine can be suddenly shattered by a telephone call reporting an emergency and requesting the ambulance and the intern on duty. Or a patient may arrive unannounced, bag and baggage, for immediate hospitalization. He comes from a distant part of the province; his doctor has told him that he should have surgery done and so with no warning and without even an explanatory letter from the doctor, he boarded the first train for the city. It is up to the admitting officer to sort out this tangle.

The patient can be sent back home again with the very good excuse that he was completely unannounced. However, after he has been seen by the doctor, the admitting officer may realize that he simply can not be sent home again. A place must be found for him somewhere, if only temporarily.

The Nurse and the New Patient

JULIA TRUDEAU

To the nurse, admitting a new patient is one of the most routine duties in her day. She tends to go through the procedure almost mechanically. That is why she needs to be reminded that for the patient, this is a crisis in his life.

THIS IS a familiar theme but one of prime importance in the development of the truly competent nurse. For those who are experienced in nursing, the opinions expressed here may contain nothing new. Nevertheless, let us review the different steps in the admission of a patient from the nurse's point of view. It may prove beneficial to some and give others a sense of satisfaction in a job well-done. The nurse's role will be considered from both the psychological and technical points of view.

In the life of the hospital, the admission of patients is a daily occurrence and, unfortunately, a routine one. This same situation applies to the nurse's work. During her professional career she will admit an undetermined number of patients. However, if this is an every-day event for the nurse, it is not so for the patient. As far as he is concerned, he is the only patient in the hospital and his admission is a major, if not particularly happy, experience in his life. Often it acts as a shock or a psychological trauma. This is where the nurse's role in helping him to adjust under the best possible conditions and with the least stress becomes important. First impressions tend to remain and the nurse should put forth every effort to develop a favorable attitude in the patient towards his hospitalization.

What should the nurse's attitude be towards each new patient? Let us look at the matter objectively. She should see each one as an individual presenting a fresh field for action in physical, psychological and moral care. Her time, her knowledge, her ability should be expended upon each newcomer as if he were the first. She will receive her patient as he should be received — with the kindliness that alone is capable of inspiring confidence. Her expression, her words, and her gestures will convey calm reassurance. She will accept the fact that the patient has a right to her sympathy and her care. She should be compassionate and tactful in helping him adjust to his new state and surroundings and avoid causing him any unnecessary mental anguish. Remembering that this is a suffering human being, dependent upon hospital services, she will observe him closely to determine his personality and his needs in order to understand better his physical and mental reaction to his illness. She will view him within the setting of his social, familial and financial background.

Except under emergency or unusual circumstances, arrangements for admission should be made 24 hours or more before the patient comes to hospital. The admission period should extend over another 24 hours to take into account all those members of the personnel who will be caring for the patient during his stay in hospital. This is an important and necessary step since it fosters a good adjustment to the patient's new environment and activities. Not only is he ill when he come into hospital, but he is away from familiar home surroundings.

In saying that admission arrangements should precede the patient's arrival by 24 hours or more, we also assume that the hospital in question will send out a folder explaining what can be expected on admission. Certain necessary forms could be included and filled out prior to admission, thus avoiding irritating complications on arrival at the hospital. Classification of his illness and reception of the patient into hospital would be facilitated. This procedure will also help to avoid the necessity for transfer following hospitalization. No patient ever appreciates

Miss Trudeau is assistant director of orientation for nurses at Notre Dame Hospital, Montreal.

a sudden transfer from one service to another — and our aim is to keep him as happy as possible.

The patient's arrival at the hospital is set for a specified hour. The admitting office should notify the department concerned far enough in advance to have the new patient received in the smoothest manner possible. The head nurse *must* be warned of all new arrivals since she is directly responsible for the welcome accorded each one. The reception of the new patient will be all the more cordial when she is forewarned and prepared.

On the ward preparation includes inspection of the room for tidiness and cleanliness. The bed covers should be folded back, and the whole appearance of the room should produce a pleasing impression. The observant nurse will see to such details as straightening the drapes, adjusting the window blinds, putting objects back in position. Defective equipment should be restored and any other repairs should be carried out in advance. A squeaky bed, a noisy door, a dripping tap, a stuffy room — all these need to be remedied before the patient arrives.

After being received in the admitting office, the patient is taken to his ward by an attendant who also brings the admission slips carrying the patient's name, address etc. The head nurse, having been prepared of his arrival, gives the patient a friendly greeting and introduces him to the nurse who is to be responsible for his care — perhaps the team leader — and she takes him to his bed.

The patient is almost always accompanied by relatives or friends who, quite naturally, want to go with him to his room. They should be shown every courtesy. They must be reassured concerning the patient's care. Their anxiety must be relieved and their cooperation obtained. Either the nurse responsible for the patient or the head nurse will answer the questions asked by the relatives. Explanations must be clear to help them to understand the requirements of the hospital. By so doing, possible misunderstandings are averted, the patient is helped and the good name of the hospital is protected.

The chart, name plate and identification band are brought to the ward later. It would be very desirable to add the charts from previous admissions or from attendance at outpatient clinics immediately.

After the patient's initial orientation to his environment, the nurse, assisted by the nurse's aide, helps him to get settled. She sees to the convenient arrangement of his personal effects. If he is not in a private room, she indicates the area in the ward that belongs to him specifically. If his clothing is to be kept in hospital, the nurse fills out the appropriate forms. After the patient or, if he is not able, one of his relatives has signed the form, it is attached to the chart. The clothing is labelled and locked away. Valuables, such as money and jewellry, are given to the relatives or to the head nurse. If the head nurse takes responsibility for them, the articles are placed in a special envelope with the patient's name, address and bed number on the outside. The envelope is sealed in the owner's presence and then he signs it. The envelope is placed in the hospital vault after having been countersigned by a responsible member of the business office staff who also gives a receipt to the bearer. The patient must be warned that the hospital takes no responsibility for valuables kept in his possession.

The nurse must instruct the patient in hospital routine as part of the adjustment process. This should be spread over the first 24-hour period. The patient should be introduced to the other people who will be concerned with his care, including student nurses and nurses' aides. The nurse will explain to him that these people make up the team responsible for giving him all the care he may require in the most pleasant way possible. She must be ready to listen to what the patient has to say about his own special problems since it will help her to understand him better. One can often do more good by listening than by talking.

Hospital rules are clarified so that the patient may feel at ease. He is made to understand that the rules are there to ensure smooth functioning of hospital activities. The patient must be familiarized with the physical set-up: the call-bell, intercommunication systems, lights, windows, the bed — if it is raised and lowered electrically,

he must be shown how to operate it, the bed screens, the position of the wash basin, bath and shower. This helps him to feel at home in the new environment which is an important factor in assuring good morale.

If the patient is admitted just at mealtime or slightly after, find out if he has eaten and give him something if he has not and if it is permissible. It is always better to have a doctor's order in this regard. The nurse must carry out certain steps in the patient's care before the doctor's arrival. The patient must undress and either get into bed or be comfortably seated. The nurse must check to see that he is clean and, if not, he should have a bath. If ambulatory, he must be weighed. His temperature is taken. In each instance an explanation must be given. Finally, the nurse should be sure that the patient is comfortable generally and that all necessary details have been attended to before she leaves him.

The nurse's next duty is to give an account of her observations to the head nurse and to call the doctor and intern. The head nurse must check to see that she has sufficient personnel on hand to ensure that all new patients will receive treatment as prescribed. The chart, Kardex and requisition forms must be seen to next.

During the first 24-hour period in hospital, every new patient has various treatments and examinations. It is most important that each one be explained to the patient and that he should be given advance notice. This avoids a fresh surprise each time for the patient and prevents delays or blunders. A physical examination is the first requirement. The nurse must help the patient to understand the necessity for this and she must win his cooperation. She assembles the equipment needed by the doctor and assists with the examination.

The staff on each shift must be made aware of the new patient on the ward. The system of reporting must take into account the steps necessary to ensure continuity of treatment. Use of the Kardex and conferences with the team leaders are methods of notifying each nurse of the new patient's arrival. The nurse is responsible for assigning auxiliary personnel duties in connection with the new arrival.

If this pattern is followed, a superficial attitude is avoided. The patient quickly becomes aware of the sympathetic attitude towards him and the general serenity of the atmosphere. But we still have work to do before we will have attained the ideal in our admission procedure.

Vegetable oils, commonly used in cooking and in salads, have come to the aid of diet-conscious teen-agers, who suffer from acne. Dr. W. R. Hubler, Corpus Christi, Texas, has said that corn oil, used as a dietary supplement, prevented weight loss and fatigue often associated with low fat diets — a frequent acne treatment.

In one group there was remarkable improvement in the skin and general condition of five patients. None of the patients became worse when corn oil was added to their diets. In another group of 180 patients studied, the acne condition seemed to subside more rapidly than in patients treated prior to the use of corn oil. It was necessary to resort to x-ray treatment in only five instances in order to produce clearing of their acne.

Even patients who suffered from acne in its worst form improved with remarkable rapidity with the use of corn oil. All acne patients treated by this doctor now are allowed to use corn oil freely in their diets. Seventy-five patients have also used an unsaturated corn oil oleomargarine on their bread without apparent deleterious effects.

The Texas physician pointed out also that he had found that ingestion of corn oil did not influence the normally low cholesterol levels of the teen-agers in any way.

— *Archives of Dermatology*, American Medical Association.

* * *

Death's no punishment: it is the sense, the pains and fears afore, that makes a death. — Sir John Suckling

* * *

The vagabond, when rich, is called a tourist. — Paul Richard

The Patient comes to Hospital

DENISE FORTIN, B.Sc. ED.

No nurse can truly empathize with the patient who is being admitted to the hospital for the first time. Why? She, at least is no stranger to a hospital — for the new patient it is an environment unknown.

THE remarks which follow are the results of observations made as a head nurse, and as a patient since I have had this experience on several occasions. To give greater objectivity, the opinions volunteered by certain persons who have been hospitalized at one time or another in their lives, have been added.

This is not intended to be a scientific exposé concerning the psychological reactions of the patient upon admission to hospital. I simply appeal to your feminine intuition and natural understanding when I ask you to consider with me what the human being has to go through when hospitalization is necessary.

We will find that there are as many different reactions as there are patients. Mrs. Brown who arrives in hospital on her own two feet for a medical check-up, certainly will not have the same feeling about it as Miss Kay who is brought to the ward by wheelchair and in great pain, or Mr. White who left his home by ambulance. The chronically ill patient who comes into hospital periodically will exhibit attitudes which may not appear in the person brought to hospital under emergency conditions. All of these categories, if superficially different, have fundamental resemblances when we remember that they are all human beings.

As a first step let us find out what the identifying characteristics of human beings are; what factors relate one to another and draw men together fundamentally, so that we may have a better understanding of the state of mind of the person who must be hospitalized.

Every individual on earth is possessed of a human nature, a nature at once equal and divided, equipped with powers requiring constant use. The powers of thought, of desire, of imagination, of feeling seek expression continually. This manifestation can be easily influenced or changed by circumstances in one's life (illness is one of these), through exposure to a new environment (for example, hospitalization), or through the behavior of those around one. If we admit that individuals possess essentially the same nature, the same psychological make-up, then we must also admit that inherent in their nature are certain basic needs that must be met. What are they?

1. The need for security
2. The need for appreciation, affection, attention
3. The need for growth

Then can you dispute that the human being as he really is tends toward one end—happiness? Having admitted that all individuals, regardless of their differences, are fundamentally the same in nature because of their inherent needs and their common goal, it is much easier to appreciate what takes place in the heart, mind and soul of the person who has to be hospitalized.

From the moment he comes into the hospital, the patient becomes prey to a nagging sense of insecurity. In the admitting office, he must face a barrage of questions which no doubt has a purpose but does nothing to cheer the patient and, in my humble opinion, is not very gracious. I am perfectly aware that institutions must live but is it really necessary to embarrass people to death? I found this procedure difficult to accept but I have confidence that the efforts being put forward to improve the lot of patients in other respects will lead "the powers that be" to devise a more acceptable and less traumatizing method for this aspect of

Miss Fortin is an instructor in the school of nursing, Notre Dame Hospital, Montreal.

the admission procedure.

Upon leaving the admitting office, the patient is taken to his room. At some moment, he finds himself alone, facing the unknown and its disquieting possibilities. He asks himself all sorts of questions.

Why did he come in anyway?
Will he have to stay for long?
What will they do to him?
What will it cost?
How will he be treated?
Will they really be as interested in him as he has heard?
Will he be able to sleep? to eat?
How will he get along?

So many questions, so many answers that it is important for him to have! Will he have a chance to ask about them? With a quaking heart, aching head and an anxious mind, he waits apprehensively. Happily, he finds himself in a hospital with kindly nurses who attend to him as quickly as possible, greet him smilingly, bid him welcome, and explain things to him so that he knows what to expect. Welcoming the new patient properly is so very important! The only welcome that can truly satisfy the new patient's need for security is, I believe, far beyond the rules of protocol outlined in our books on etiquette. It encompasses that attitude towards the sick which is conducive to the necessary and comforting human contact.

Have we not been struck by the effect on the patient of the endless stream of people who go in and out of his room so impersonally, especially in the first 24 hours? Each time the door opens the patient is on the alert. Somebody comes in to take blood; somebody else brings in an examination tray with its mysterious contents. An intern in quest of an interesting "case" to round out his experience as a budding clinician arrives on the scene. The dietitian pays a visit; the nurse's aide brings in a glass of fruit juice (and the patient wonders if he should drink it); the nurse delivers his meal tray; and a representative from a television agency comes in to see if his services are required. Unless the appearance of each one of these various categories of personnel is explained and justified, will not all this coming and going simply serve to increase the patient's insecurity?

Besides the new patient's need for security, which it is so imperative to satisfy, is it not also true that the need for appreciation is similarly imperilled?

Since the normal human being has as much need, if not more, of being respected, appreciated and loved as he has of eating and sleeping, do you not feel that the anonymity with which we tend to surround him during those first few hours in hospital must be distressing? And how about all the labels that we attach to him? They do nothing to personalize him. We should never forget that the patient is a person with a name, a family, social status, with his own views on life and his own special characteristics. He has a personal value that must be recognized. If we want him to feel respected and liked from the beginning, we must look upon him as a man first and a patient last. If we notice that a patient seems to have a feeling of inferiority, everything possible should be done at once to build up his confidence and self-respect.

What other conclusion can we draw from this than the need to show greater consideration for the patient from the moment of his arrival so that we may see him in his true light and by the warmth of our manner lessen the insecurity and anxiety that plague him.

For truth itself has not the privilege to be spoken at all times and in all sorts.
— MONTAIGNE

* * *

The rung of a ladder was never meant to rest upon, but only to hold a man's foot long enough to enable him to put the other somewhat higher.
— THOMAS HENRY HUXLEY

* * *

There is great ability in knowing how to conceal one's ability — LA ROCHEFOUCAULD

PREPARED IN YOUR NATIONAL OFFICE, CANADIAN NURSES' ASSOCIATION, OTTAWA

Happy New Year

Agnes Campbell Neill Memorial Award

Through an educational award, the members of the Nursing Sisters' Association of Canada are proud to honor the memory of Matron-in-Chief, AGNES CAMPBELL NEILL, OBE, RRC, LLD.

A graduate of the Toronto General Hospital, Agnes Neill served for ten years in increasingly important supervisory and teaching positions in her own hospital and school of nursing, latterly as junior assistant to the renowned Miss Jean I. Gunn, superintendent of nurses.

As an international student at Bedford College in 1935-36, Miss Neill gained knowledge of hospital administration which was later reflected in her able organization of the Royal Canadian Army Medical Corps nursing service abroad. From her enlistment in the first month of the war and subsequent assignment overseas as Captain (Matron) until her return to Canada five years later as Colonel (Matron-in-Chief), her record of service to her country and to her calling "tells better than any words the story of Agnes Neill, the woman, the nurse, the officer." To these words every nursing sister whose privilege it was to serve with her, would unquestionably wish to add "the friend."

Returning to civilian life, her great heart for veteran justice naturally drew her to a posting with the Department of Veterans Affairs. But veterans, doctors, nurses and friends everywhere were all too soon to be saddened beyond measure, for Agnes Neill died on the 5th of May, 1950.

As a loving remembrance of a noble, happy person; as a symbol of her outstanding professional leadership; as a continuation of her life's work, the first Agnes Campbell Neill Memorial Award will be made at the time of the 30th Biennial Meeting of the CNA being held in Halifax, June 19-24, 1960.

The following information regarding this Award is presented for the benefit of those nurses who might wish to apply for this scholarship.

AWARD

1. The amount of the Award shall be $500.
2. The Award shall be given every two years to a suitable candidate who is planning to further her nursing education through university study and who meets the requirements set by the Nursing Sisters' Association.

APPLICANTS

1. Applicants for the Award shall be nurses who are registered in a province in Canada. Preference shall be given to:
   (a) Former nursing sisters who have served in Her Majesty's Forces.
   (b) Relatives of nursing sisters or veterans.
   (c) Other veterans who have served in the Allied Forces.

APPLICATIONS

1. Application forms may be obtained from the Canadian Nurses' Association, 74 Stanley Avenue, Ottawa, Ontario.
2. The processing of applications will be carried out by the Agnes Campbell Neill Memorial Award Committee with the assistance of the CNA.
3. The CNA will provide professional advice to the Nursing Sisters' As-

sociation or their representatives with regard to qualifications of applicants.

4. ***All applications must be received at CNA Headquarters not later than May 1st, 1960.***

Halifax Headlines

PEARL STIVER, our general secretary visited Halifax in October to attend a meeting of the Sub-Committee of the Committee on Legislation and By-Laws and to meet with members of the Arrangements Committee for the 30th Biennial Meeting, June 19-24, 1960.

Miss Stiver reports that convention plans are well underway. All persons involved in planning, local CNA members, Halifax citizens and the RNANS are enthusiastic in their endeavor to make this meeting a memorable one. CNA members can be assured that the 30th Biennial meeting of the CNA will fulfill their greatest expectations, program-wise and otherwise.

Don't miss this opportunity to meet with old and new friends and to share with our Maritime nurses the results of their endeavors. A warm welcome awaits you.

Action and Reaction

This was the theme of the RNAO Fall Conference held at Honey Harbour, Ontario, October 3-7, 1959. This conference was designed to improve the ability of nurses to work together and with others in identifying and solving problems. About 150 nurses attended, representing hospital, public health and industrial nursing fields. LILLIAN CAMPION, our Nursing Secretary, was privileged to attend as "Group Trainer." Miss Campion shares with us her impressions of this conference.

MRS. LYDIA HALL, director of Loeb Nursing Centre Project, Montefiore Hospital, Bronx, New York and DR. ROBERT CROOK, assistant professor, Queen's College, New York (they soon became known as Lydia and Bob) led the conference. Mrs. Hall spoke on "Society Health Needs" and in her second talk she gave her concepts of nursing. This she described as a process going on between the patient and the nurse. This process has three interwoven aspects: intimate bodily care, medical care and therapeutic use of self. She emphasized that nurses must help the patient participate in stating his problem and work with him in meeting this problem. There is a need for individuals to verbalize their feelings and nurses should help the patient develop an undertanding of his emotions and to mature physically and emotionally. There was much in her talks to stimulate discussion and provoke thought. The content provided numerous topics for group discussion.

Miss Campion tells us it was a most valuable experience to work with Dr. Crook, an expert in group techniques, in the trainer's role and to observe him put his theories of group work into practice as he so skilfully worked with large and small groups.

The role of a trainer was a new experience to many of the nurses attending the conference. A "group trainer" is not a group leader. Rather, his function is to observe the group process and to intervene when the group seems to be in difficulty. The group trainer may intervene when a group is unable to identify a problem, establish a common purpose or when group antagonisms develop. He helps the group look at what is happening and understand some of the underlying emotions affecting group behavior.

"All work and no play makes Jack a dull boy." Planners for Honey Harbour conferences believe wholeheartedly in this maxim. The daily program consisted of general sessions, small group discussions and recreational periods. Sometimes sessions were held in the evening permitting the nurses to enjoy the fall beauty and splendor of Ontario's Muskoka district in the afternoon sunshine.

Planned recreational activities included a tour of the harbor and part of Georgian Bay by launch, picnic lunch on Beausoleil Island, a barbecue supper and an evening dance. Many nurses enjoyed walks through the countryside and swimming.

All good things must come to an end. Miss Campion returned to Ottawa by car via Algonquin Park which was ablaze with beautiful fall colors — a lovely finale to a most stimulating week.

Fellow of WHO on Study Tour

Miss ALISON CATHIE, instructor at the New Zealand Nurses' Post Graduate School and the recipient of a WHO Scholarship is at present completing a study tour in Canada.

She has visited nursing education centres in four provinces. Miss Cathie is mainly interested in the integration of nursing education into nursing service.

VON House, November 1959

VON House, Ottawa, was the scene of great activity last November when 35 visiting nurses, representing Canada from east to west, attended the biennial conference for regional and district directors sponsored by the Victorian Order of Nurses for Canada.

The theme was Leadership and Interpersonal Relations. Mr. JOHN KIDD, executive director, Canadian Citizenship Council, Ottawa, was conference director, ably assisted by Dr. ALEXANDER LAIDLAW, national secretary, Cooperative Union of Canada; Mr. JOHN HARCOURT, director, Planning and Development Branch, Civil Service Commission; Mr. WALTER HERBERT, director, Canada Foundation and secretary, Canadian Association of Adult Education; Dr. F. R. WAKE, professor of psychology, Carleton University, Ottawa and Miss CHRISTINE LIVINGSTON, Director-in-Chief, Victorian Order of Nurses for Canada.

After identifying the reason for their presence the group sought to identify their problems. Inspiring addresses were given on subjects relating to professional and personal growth, supervision, counselling and guidance, the Victorian Order nurse and her publics and, that ever-present monster, decision-making.

Group discussions followed the main addresses and each group presented their reports to the general session. Discussion leaders were Miss PHYLLIS BURNS, director of Welfare Services, Canadian Welfare Council, and Miss LILLIAN CAMPION, nursing secretary, CNA.

All VON personnel across Canada will benefit from this conference as the directors share with them the wealth of knowledge gained during the sessions. The answer to Miss Livingston's question "Where do we go from here?" will be forthcoming in improved nursing service.

This is a shoe tester for operating rooms that instantly signals the static-charge conductivity of footwear. A person steps onto the instrument's two metal plates located close to the floor. If the shoes are satisfactory, a light on the unit shines. But if the combined resistance of both shoes and body is more than 1,000,000 ohms the light remains off. In that case the shoes must be cleaned thoroughly and tested again.

"Lite-Rite" Shoe Tester

The device, called the "Lite-Rite" Shoe Tester, is equipped with test buttons to show that the unit is in working order and is properly calibrated. For further information write to: National Cylinder Gas Division of Chemetron Corporation, 840 North Michigan Avenue, Chicago 11, Illinois.

* * *

Aspirin may be dangerous for the patient who has a peptic ulcer. Acute gastric hemorrhage has been known to occur usually as a result of acute gastric erosion, even if the patient has an associated duodenal ulcer. A soluble form of aspirin is probably safer if the patient has to receive the drug.

* * *

A doctor who was listening to a woman's ailments and taking down all the pertinent facts, asked her age. Even after repetition of the question there was complete silence. "Oh come now," he finally said impatiently, "just make a wild guess."

Nursing Profiles

The appointment of **Peggy Nuttall** as editor designate of *Nursing Times* has been announced by the Council of the Royal College of Nursing, London, England. She will replace **Marjorie Wenger** who, unfortunately, has had to resign her editorship for health reasons.

Miss Nuttall began her professional career by taking training in physiotherapy at the London Hospital. She subsequently held posts at several London institutions as a practising physiotherapist and as a teacher. Later, nursing attracted her and she entered St. Thomas' Hospital, from which she graduated with distinction in 1955 as winner of the Gold Medal. Miss Nuttall also received the Maternity Prize from the East End Maternity Hospital where she took her midwifery training. Following completion of her professional preparation, she was appointed as a charge nurse at the Royal Waterloo Hospital and later became senior night assistant at St. Thomas' Hospital. In 1958 she came to the staff of *Nursing Times* as assistant editor.

PEGGY NUTTALL

It is with pleasure that we extend warm good wishes to Miss Nuttall in her work with a professional journal that is well-known to Canadian nurses.

It is with great regret that the president and board of management of the Victorian Order of Nurses for Canada have announced the retirement of **M. Christine Livingston.** The nurses who staff the VON units across the country, friends, colleagues and acquaintances will echo this emotion with even greater feeling. Miss Livingston has been director in chief of the Order since 1949, having previously served as a staff nurse in Montreal and in various other capacities including assistant superintendent and supervisor with national office. In all she has served the Order for 27 years.

(Paul Horsdal Ltd.)

M. CHRISTINE LIVINGSTON

Upon graduation from Hamilton General Hospital, Miss Livingston went to the University of Toronto to study public health nursing. After obtaining her certificate, she returned to the social service department of H.G.H. and subsequently joined the health department of the City of Hamilton. Later she attended Columbia University where she obtained her B.S. degree, majoring in administration and supervision in public health nursing. In 1952 she was awarded the Coronation Medal in recognition of her services.

Her professional connections have been many and varied. She is an officer-sister of the Order of St. John of Jerusalem; a Fellow of the American Public Health Association; a member of the Canadian Red Cross Advisory Nursing Committee, St. John Ambulance Advisory Nursing Commit-

tee, National Committee on Aging and the executive council of the Canadian Public Health Association. As one of our Canadian leaders in nursing, her touch will continue to be felt through the work of organizations such as these.

Regrettable as her retirement from active nursing is, her desire to have the opportunity to enjoy her home more fully, to indulge in the personal pleasures set aside so often to meet professional demands, is most understandable. We wish for her a full and happy life in the years ahead.

(Nat. Defence Photo, Canada)

MAJOR M. E. DEWAR

Margaret E. Dewar was recently appointed for duty on the staff of the Surgeon General, Canadian Forces Medical Services. Major Dewar is a graduate of the Toronto General Hospital. In 1939 she joined the Royal Canadian Army Medical Corps and served in England with No. 15 Canadian General Hospital. Following her return to Canada, she served as matron of military hospitals in Toronto, Kingston, Montreal and Calgary. She was awarded the Royal Red Cross in recognition of her services.

Edna E. Andrews recently retired from the Canadian Army after almost 18 years of service. Major Andrews graduated from the Saskatoon City Hospital in 1931 and joined the RCAMC in 1941. She went overseas in the following year and subsequently served in Canadian general hospitals in the United Kingdom, France, Belgium, Holland and Germany. In 1945 she was made an associate of the Royal Red Cross.

(Nat. Defence Photo, Canada)

MAJOR E. E. ANDREWS

Following her return to Canada in 1946 she served as matron of military hospitals at Calgary, Whitehorse and Toronto. In 1950 she became Matron-in-Chief, RCAMC — the position from which she has announced her retirement.

JENNIE IVES

The Ontario Hospital Services Commission has announced the appointment of **Jennie Evelyn Ives** to the nursing consultant staff. Until accepting this position, Miss Ives had been Nursing Service Secretary with the Registered Nurses' Association of Ontario.

She is a graduate of Belleville General Hospital and has done postgraduate study at the University of Toronto and at Columbia University where she received her B.S. degree, in 1957. Prior to her appointment to the RNAO staff, Miss Ives had served on the faculties of Collingwood General Hospital, McKellar Hospital, Fort William and Toronto General Hospital. In 1943 she became assistant director of nurses at T.G.H. and retained this post until 1957. Her background of professional experience and her administrative ability will be valuable assets in her new field of work.

(Ashley & Crippen)

BLANCHE DUNCANSON

This year the Ontario Hospital Services Commission will establish the Nightingale School of Nursing — a pioneer project of the organization. Directing the activities of the new school will be **Blanche (McPhedran) Duncanson,** a graduate of Victoria Hospital, London, Ont. and of the University of Western Ontario where she obtained her B.Sc.N. degree.

Mrs. Duncanson is widely experienced in the field of nursing education. The present program at Toronto Western Hospital School of Nursing was developed under her guidance during the years 1949-58. More recently she has conducted a survey among schools of nursing in the province of Manitoba; directed a study of registration examinations on behalf of the Registered Nurses' Association of Ontario; conducted institutes in the provinces of Nova Scotia and Quebec relative to the Pilot Project and one in nursing arts at the University of New Brunswick to assist nursing instructors to incorporate principles of nursing throughout the curriculum.

Her acknowledged skill as an administrator and as an educator assures the new school of expert guidance and leadership. The congratulations and good wishes of friends and colleagues are extended to her.

Grace Patterson has been appointed director of nursing for The Toronto Western Hospital. She is a graduate of the school of nursing of this same hospital and since 1950 has been associate director, nursing services.

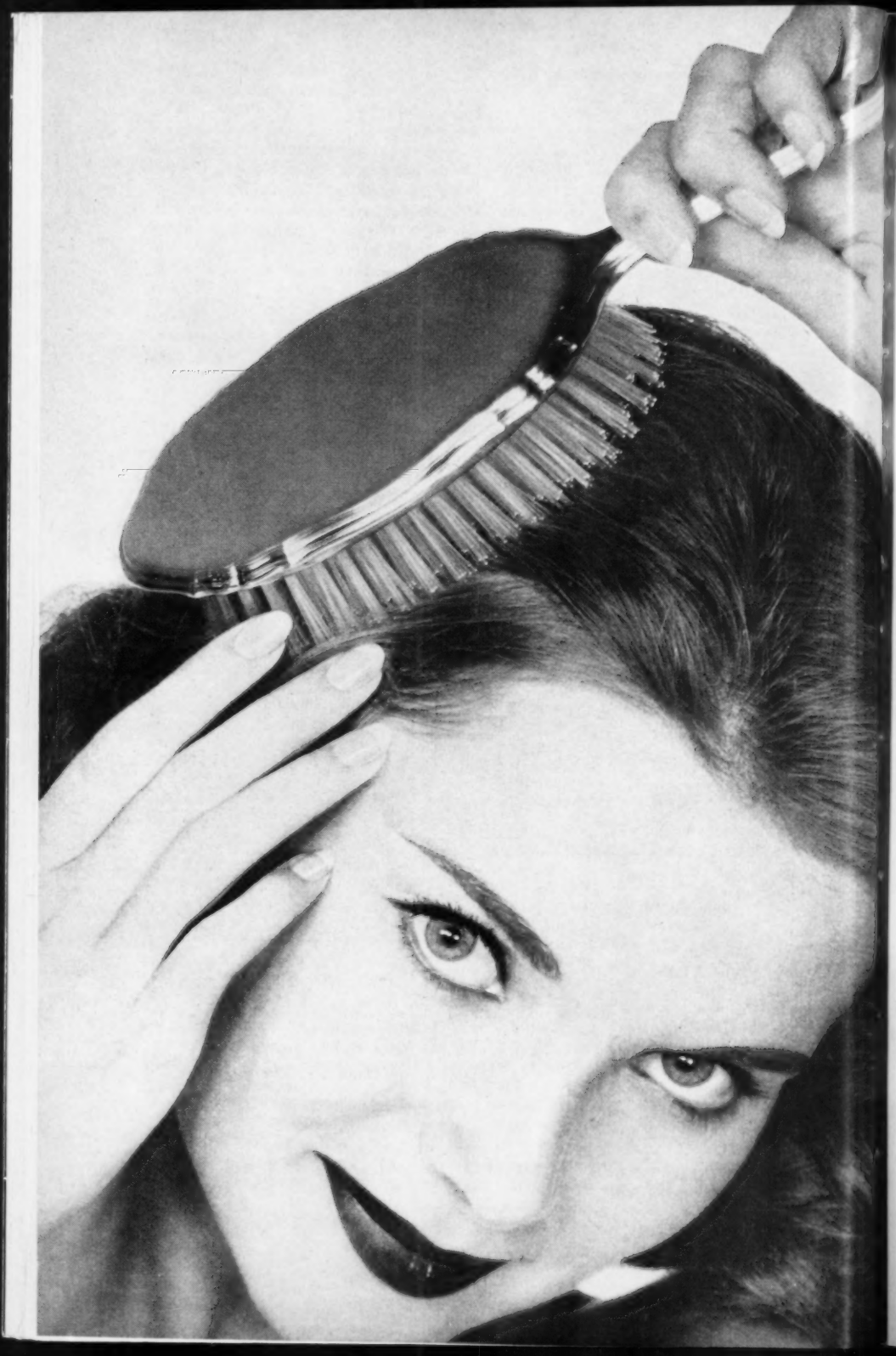
During World War II Miss Patterson served overseas with the RCAMC and when war ended, was principal matron with the rank of major in charge of No. 12 Canadian General Hospital in France. She was twice decorated with the Royal Red Cross in tribute to her outstanding military service. After her return to Canada Miss Patterson studied hospital administration at the University of Toronto and later completed requirements for her Bachelor of Science degree in nursing at Columbia University.

(Le Roy Toll)

GRACE PATTERSON

Her rich background of experience, her administrative ability, her complete familiarity with the aims and objectives of this hospital and its school ensure capable and devoted guidance of nursing activities.

Good, the more communicated, more abundant grows. — JOHN MILTON



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- ☐ 1. Rosenberg, S., Oster, K.A., Kallos, A. and Burroughs, W.: A.M.A. Arch. Dermat. 76:330, September 1957.
- ☐ 2. Schwimmer, M. and Mulinos, M.G.: Antibiot. Med. & Clin. Therapy 4:403, July 1957.
- ☐ 3. Rosenberg, S. and Oster, K.A.: Conn. State Med. J. 19:171, March 1955.
- ☐ 4. Tyson, T.L.: J. Invest. Dermat. 14:323, May 1950.

Your Name and Address

Talk of Many Things

HELEN L. BOLGER, B.S.

A summary of the conference of executive secretaries and registrars held in September, 1959.

PROFESSIONAL STAFF MEMBERS of the ten provincial nurses' associations and National Office, Canadian Nurses' Association, assembled at McGill University, Montreal, Quebec, for an institute during the week of September 14-19, 1959. Miss Margaret Kerr, executive director and editor of *The Canadian Nurse* was the chairman for all sessions except those held on Thursday, September 17 when Sister Mary Felicitas, Director of Nursing, St. Mary's Hospital, Montreal, and chairman of the national Committee on Nursing Service officiated.

Attention was focused on the responsibility of nurses' associations for leadership in the following areas:

Research in nursing.

Direction of employment relations for nurses.

Facilitation of interprovincial and international registration of nurses.

The first two days consisted of lecture-discussion periods on employment relations under the direction of Miss Frances Goodall, C.B.E., S.R.N., who is chairman, staff side for the Nurses' and Midwives' Whitley Council, Great Britain. The moderator for this session was Mrs. Mary F. Strong, nursing consultant, Personnel Relations, Registered Nurses' Association of Ontario. One day was devoted to a discussion of the understanding of human relationships, the knowledge of conditions under which people work, relationships between various types of staff, and between these and management.

Miss Goodall pointed up quite forcibly that nurses' associations should take responsibility for the direction of employment relations for nurses and provide arbitration facilities for their members. She stated quite emphatically that she did not approve of nurses joining labor unions because they are then a party to strikes which upset the community where they work. As professional people we do not want or need to strike; we can use other measures if we have a proper channel of communication with management. That channel should properly be under the direction of nurses' organizations. For the past few years, nurses in Great Britain have conducted national nurses' conferences to which they invited doctors, hospital and agency administrators. The majority in attendance were nurses, but all were in a position to promote improvement in employment relations for nurses.

On the second day, Miss Goodall gave detailed information on the background, constitution, arbitration, conciliation and disciplinary measures of Whitley Councils. "The name Whitley and the pattern of organization of these Councils stems from World War I," Miss Goodall said. The name honors Mr. J. H. Whitley, a former speaker of the House of Commons. After the First War it was realized that labor relations needed a complete reorganization and a special committee in the House of Commons was appointed to study the question. The terms of reference were: to make and consider suggestions for permanent improvement between labor and management, and to recommend means of improving industrial relations for the future as well as to review these recommendations from time to time. The study of this Committee resulted in five steps:

1. The formation, in well organized industries, of Joint Industrial Councils.

2. The appointment of Joint Works Committees composed of management and staff.

3. The establishment of statutory regulation of wages in badly organized industries.

4. The establishment of Courts of Arbitration.

Mrs. Bolger is executive secretary of the Association of Nurses of Prince Edward Island, Charlottetown, P.E.I.

5. The authorization of the Minister of Labor to hold enquiries regarding disputes.

When the National Health Services Act was passed in 1948 the Minister of Labor was empowered to provide methods of payment of members of National Health Services. At this time nurses gave inspiration in giving direction to the provision of such methods, because the vocation of nursing had been exploited tremendously.

After many meetings of representatives from many of the health professions, it was agreed to have Whitley Councils deal with the problems of management and staff under the National Health Services Act. The Councils were set up under a Royal Charter with definite provision that they did not operate as trade unions.

The functions of these Councils were stated as:

1. To secure the greatest possible measure of cooperation between the authorities responsible for the nation's health and the general body of persons engaged in health services, with a view to the greatest efficiency of the services and the well-being of those engaged in the services.

2. To provide machinery for consideration of remuneration and conditions of work of persons within their orbit under the National Health Services Act.

The Whitley Council, organized on a national basis, is made up of a General Council and nine functional Councils composed of representatives from organizations engaged in health services. Each Council has representation from management and staff (labor). The organizations represent the following health personnel: administrators, clerical workers, ancillary workers, dental personnel, doctors, nurses and midwives, opticians, pharmacists, and other professional and technical workers. Each functional Council has representation from management and staff. There is a consultative group for each functional Council which works hard at getting agreement. Joint staff-consultative measures are employed continuously.

Whitley Councils may be set up on county, regional, community or hospital levels and their establishment is urged through good publicity. On request, groups will receive assistance in organizing from the national level. Such Councils have been set up all over Great Britain. Through them a great many knotty problems are being solved, and satisfactory working conditions are being established for health personnel. Miss Goodall suggested that it is not advisable to establish a Whitley Council in small units where the hospital is under one hundred beds or where the number of personnel in an agency is under one hundred.

As a first step to being organized as a bargaining agent, Miss Goodall said,

> It is necessary to learn thoroughly the history of labor relations in one's own country, the labor laws and social history of hospitals and schools of nursing. It may be necessary to revise existing nurse legislation to become empowered to negotiate regarding labor relations . . . We must remember that unions deal with matters on a material basis, but the professions deal with human elements. We deal in the eternal verities of nursing; vocation, patient and human approach, with the ultimate goals of satisfactory service to the public and a happy and satisfying life for nurses. Nurses therefore need to be good nurses; they should be good members of their profession as well as good citizens.

On September 16, a symposium on "Nurse Registration" was conducted by Miss Frances McQuarrie, registrar, RNABC; Miss Grace Motta, registrar, SRNA; and Miss Muriel Archibald, executive secretary, NBARN. Out of the discussions on registration, the following recommendations were adopted by the members present. The registrars from each province were asked to present these recommendations to the executives of their respective nurse associations and report the reaction of the same in February 1960 at the Registrar's Conference.

Registration of Canadian Nurses by Certification

WHEREAS, In each province there is an authorized body responsible for:

(a) approving schools of nursing

(b) conducting examinations to determine the competency for the practice of nursing

(c) maintaining a register of registered nurses, and

WHEREAS, The integrity of the nursing profession is dependent upon mutual confidence in the standards of

each provincial registered nurses' association, it is

Recommended, That the academic and professional educational qualifications of graduates from Canadian Schools of Nursing who apply for inter-provincial registration be considered acceptable upon submission of proof of:

(a) identity

(b) fluency in English or French, if required

(c) initial registration by a provincial registered nurses' association.

Registration of Non-Canadian Nurses

WHEREAS, Great difficulty has been experienced in evaluating the qualifications (determining equivalencies) of nurses from other countries in respect to:

(a) general academic education

(b) basic nursing preparation

(c) procurement and interpretation of individual nursing records, and

WHEREAS, Standards of nursing care in Canada are dependent upon the proficiency of all persons admitted to the profession and provincial registered nurses' associations are held responsible (usually by provincial statute) for evaluating the proficiency of registered nurses, it is

Recommended, That

1. Applicants for registration who are not graduates of a Canadian school of nursing be required to:

(a) provide proof of identity

(b) provide proof of fluency in English or French, if required

(c) provide proof of certification for nursing

(d) provide a statement of efficiency in nursing employment in Canada for a period of not less than one month

(e) qualify for and pass the registration examination of the province.

2. Applicants for registration, who are not graduates of a Canadian school of nursing be *not* required to write the provincial registration examination if the applicant can present evidence of

(a) success in the registration examination of another province in Canada

(b) success in the N.L.N.S.B.T.P. examination for professional nurses.

The last two days of the meeting were concerned with research and nursing. All the guest speakers for this part of the Institute have made notable contributions in research, each in his or her own right. They were Miss Virginia Henderson, R.N., M.A., research associate, Yale University; Dr. David Solomon, associate professor of Sociology, McGill University; and Dr. Heinz Lehmann, associate professor of Psychiatry, McGill University.

Miss Henderson, who was introduced by Miss Suzanne Giroux, official visitor to the French schools of nursing, Quebec, reminded us that research is not new in nursing. Since 1909 there have been some sporadic studies, but it was not until 1930 that evident interest was shown in applying the scientific method to nursing problems. This approach was adopted in a sincere effort to improve nursing service, nursing education and administrative procedures related to nursing service. The major emphasis at that time was placed on nursing education because there were so many problems stemming from the fact that nursing education programs were based in service agencies. Miss Henderson said

> It has been with the greatest effort that we have taken our schools out of service agencies and into educational institutions . . . The development of the scientific method in dealing with nursing problems has paralleled the development of collegiate nursing education programs. Without this we would not have much, if any, investigation by nurses . . . Because nursing is an applied science, as is medicine, we borrow the sciences and our study is bound to be a composite of the sciences of many fields. Therefore we will have a different concept of research on the one hand from groups of workers whose work is based on research and on the other hand from groups whose work itself is research . . . It is no disgrace or disadvantage to get help to study problems. This will be a great strength in the future — the working together of research teams in the solution of problems. We will need the chemists, the physiologist, the physicist, the sociologist and the psychologist.

An interesting definition which Miss Henderson gave for research was "A structural effort to solve a problem." A good part of the time she spent with us was given to the practical approach to handling a problem in research. She outlined the basic steps for solving a problem and discussed each in detail:

1. Statement of problem.

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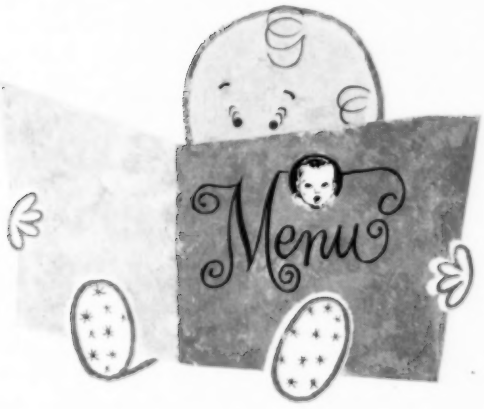

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2. Review of the literature for identification of similar work.

3. Possible breakdowns or restatement of the problem.

4. Determination of method or design of the investigation. (Statement of assumptions)

5. Collection of data, conduct of experiments, usually including a further study of the literature.

6. Recording of data.

7. Evaluation of data.

8. Report of findings.

It was heartening to learn from Miss Henderson how much assistance the libraries are giving to research workers and how much is being done by universities and libraries to meet their needs.

Dr. Lehmann spoke of the importance of a research attitude and described the typical research personality as one who has "courage, tenacity and a high frustration tolerance." He said that one must be "tolerant to himself as well as tolerant to attitudes and facts." He is such a master of the techniques of research that he made it all sound quite simple and entirely fascinating. In his outline of methods of approach to the solving of a problem, he described some interesting research that is being done in psycho-pharmacology, a specific study of "The psychological effects of wearing colored glasses" and a very mundane study that he and a student of nursing did on the problem of eliminating odors in the room of a patient with an open carcinomatous lesion.

Dr. Solomon stressed the need for formal training in research methods. He answered the question "Can anyone do research? by asking another, "Can anyone do nursing?" He reminded the nurses that there are a lot of current problems that will have to be solved administratively. He cautioned the group not to go beyond their depth in attempting to do research and to secure assistance of specialists where this is needed. "There is a place on research teams for nurses with special preparation to assist with research projects." Dr. Solomon implied that in the future this may well be the area where nurses can make their most valuable contributions to research. However, this will not happen until many more nurses avail themselves of advanced study. Discussion followed here on the need for financial assistance for nursing education, because of the great need for research in nursing and the lack of prepared people to do it.

As one who has had only elementary courses in sociology at school, I was particularly impressed with the topics for research Dr. Solomon suggested as links between sociology and nursing such as:

The anti-therapeutic effect of expecting a patient to perform in a certain way in a hospital.

A study of hostility feelings exhibited by nurses to obstetric patients.

A study of the effect on the head nurse of employing a ward secretary.

Many master's theses in the past have been centred on curriculum studies and the solving of nursing service problems. The above topics presented a completely new picture. It would seem that the days of racking one's brain for a master's degree thesis project are over, at least for a while. Not quite all the problems in nursing have been solved!

At the outset of the conference, welcomes were extended by Dr. Rae Chittick, Director, McGill School for Graduate Nurses and Miss Margaret Wheeler, president, Association of Nurses of the Province of Quebec. The nurses were entertained at teas during the week by the School for Graduate Nurses and by the Association of Nurses of the Province of Quebec.

According to the American Medical Association a vaccine which will prevent from 60 to 70 per cent of all common colds will probably be available within the next 19 months. The researcher believes that a vaccine can be developed against an acceptable proportion of the common cold.

— *Health*, Sept.-Oct., 1959

The not-so-young lady made her first investment in common stock. A short time afterwards her broker called her in some satisfaction to say he had just heard that Procter and Gamble were going to split. "What a shame" was the lady's reaction "they've been together so long."

The Canadian Doctor

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Convention Personality

1960 — a biennial year for the Canadian Nurses' Association and preparations are far advanced for the General Meeting in Halifax. Beginning with this issue some of the persons who are contributing or will contribute to the success of this event will be introduced to the readers. Unfortunately, space will not permit individual tributes to the many nurses working quietly, efficiently and determinedly behind the scenes as members of committees or subcommittees.

(Paul Horsdal)

M. Elizabeth Reed

They are the unsung heroines of every convention, the driving shaft of the whole mechanism of convention organization. Our tribute to them is our acknowledgement of the fact that without their work, there would be no General Meeting.

The first of our convention personalities is **Mary Elizabeth Reed,** the chairman of the Program Committee. As assistant director in chief of the Victorian Order of Nurses for Canada, she is a familiar figure to Canadian nurses. She is a graduate of the General Public Hospital, Saint John, N.B. (now Saint John General Hospital), holds her certificate in public health nursing from McGill University and her B.S. degree in administration and supervision in the same specialty from Columbia University.

Miss Reed joined the VON shortly after her graduation and with the exception of her military service during World War II, the connection has remained unbroken. The years 1942-46 were spent mostly in military hospitals in Canada, England and Northwest Europe. For part of that time she served in the office of the Matron-in-Chief at Canadian Military Headquarters, London, England. In 1945 she was made an associate of the Royal Red Cross in recognition of her military services.

Her professional activities include her duties as chairman, Public Health Nursing Section, Canadian Public Health Association; chairman, Agnes C. Neill Memorial Award Committee, Nursing Sisters' Association of Canada and membership on the finance committee of the RNAO. Her efforts on behalf of the program committee for this Biennial Meeting will reflect the calm efficiency characteristic of her.

Schizophrenia may involve an error in metabolism, an error that may be responsible in turn for the production of excess amounts of some toxic substance or substances in schizophrenic patients.

A study was undertaken at the Department of Neurological Research, University of British Columbia Faculty of Medicine to test this possibility. The method used was the evaluation of the physiological properties of urine extracts from schizophrenics and normal subjects.

As a first step, the over-all effects of these urine extracts on the behavior and spontaneous electrical activity of the brain were studied in cats and monkeys.

Urine extracts were prepared from samples of a group of 20 acute schizophrenic patients at the Provincial Mental Hospital; members of the departmental staff served as controls. Further studies are being conducted to determine whether the differences observed in the over-all effects following injections of the schizophrenic and normal urine extracts are quantitative or qualitative. — *Hospital Progress*, October, 1959

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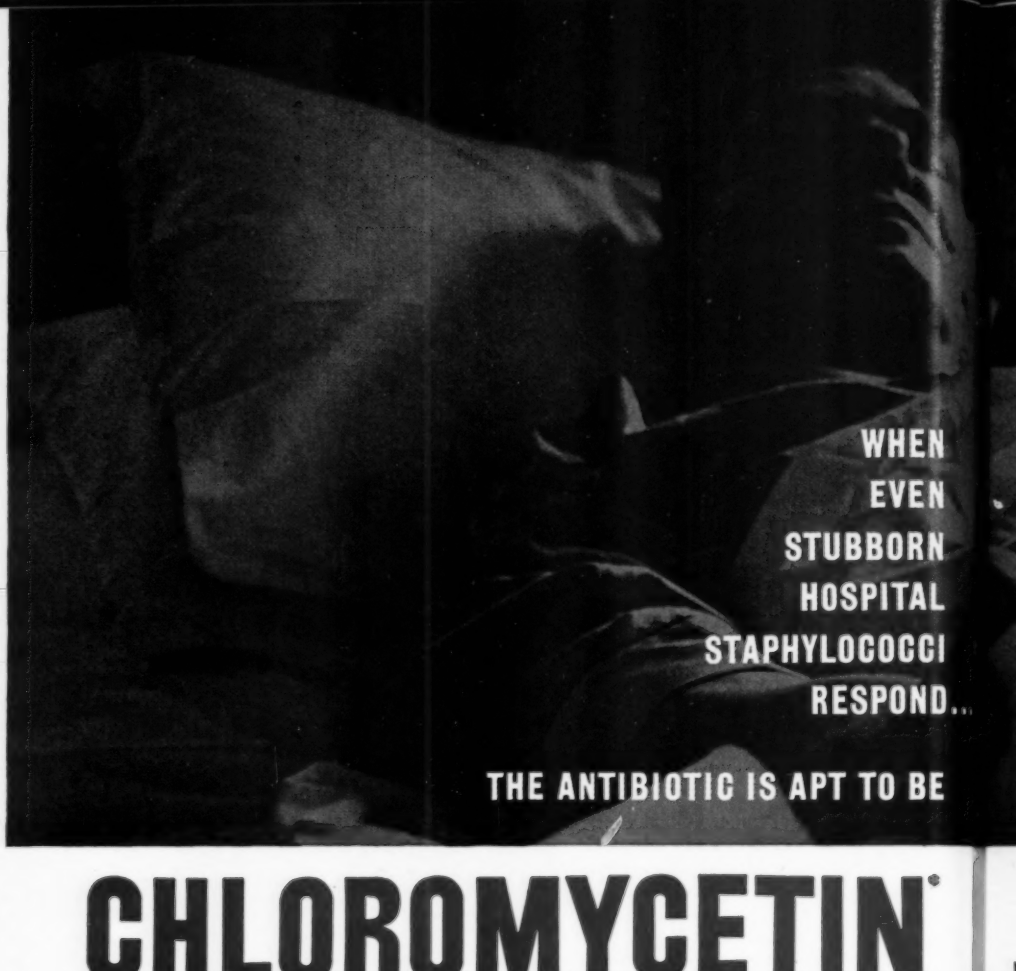

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(1) Goslings, W. R., and Büchli, K.: *Arch. Int. Med.* **102**:691, 1958. (2) Flippin, H. F.: *Am. Pract. & Digest Treat.* **10**:39, 1959. (3) Borchart, K. A.: *Antibiotics and Chemother.* **8**:564, 1958. (4) Fischer, H. G.: *Deutsche med. Wchnschr.* **84**:257, 1959. (5) Holloway, W. J., & Scott, E. G.: *Delaware M. J.* **30**:175, 1958. (6) Suter, L. S., & Ulrich, E. W.: *Antibiotics & Chemother.* **9**:38, 1959. (7) Markham, N. P., & Shott, H. C.: *New Zealand M. J.* **57**:55, 1958. (8) Ditmore, D. C., & Lind, H. E.: *Am. J. Gastroenterol.* **28**:378, 1957. (9) Schneierson, S. S.: *J. Mt. Sinai Hosp. New York* **25**:52, 1958. (10) Godfrey, M. E., & Smith, I. M.: *J.A.M.A.* **166**:1197, 1958.

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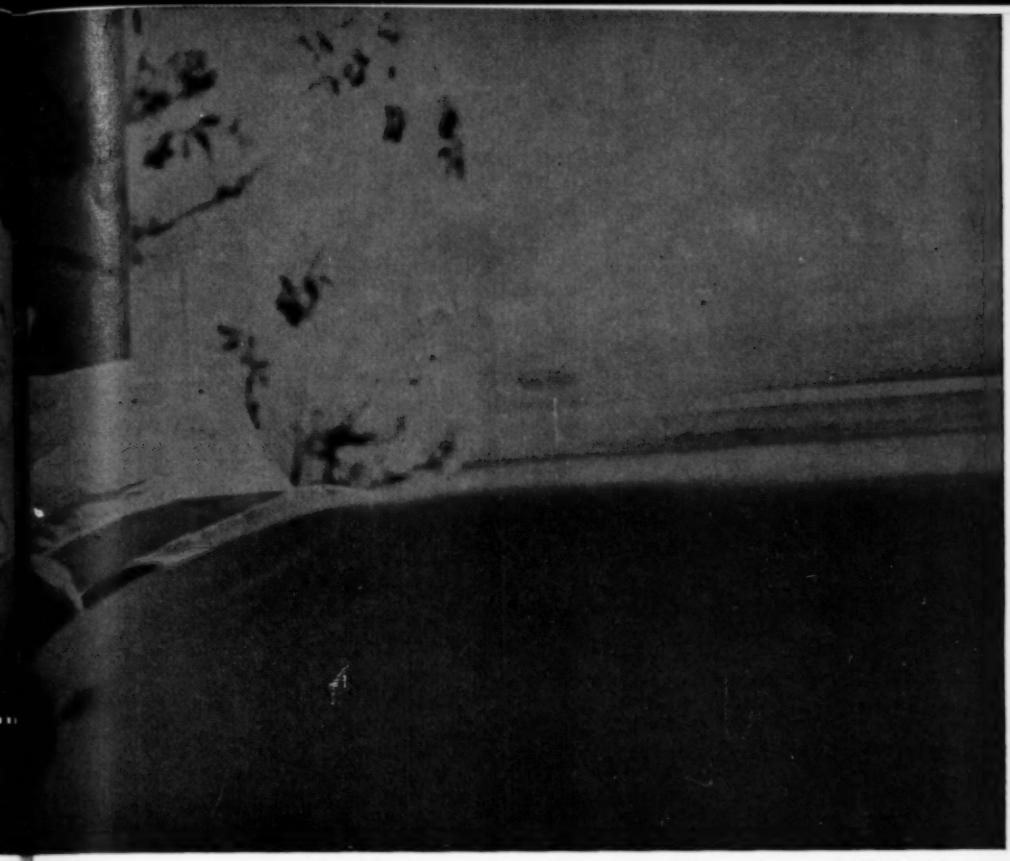

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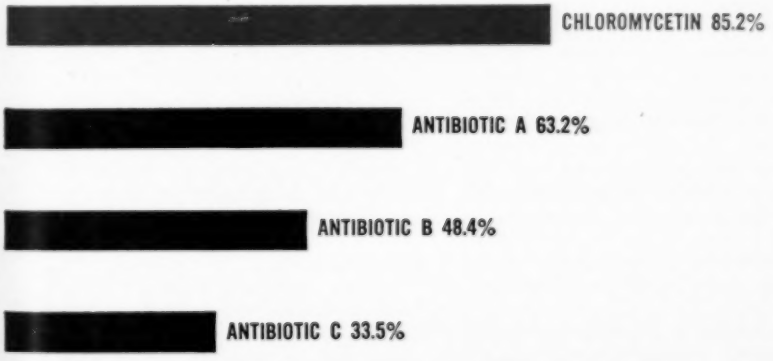

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General Paralysis

JOHN GIBSON, M.B., CH.B., D.P.M.

Although syphilis may be thought of by some nurses as a disease of the past, tertiary syphilis is found today in those who were infected 10-15 years ago. One of its forms is general paralysis of the insane which now can have a very favorable prognosis.

GENERAL paralysis of the insane (G.P.I.) is a chronic syphilitic infection of the brain and meninges, characterized by progressive dementia and paralysis. It is one of the forms of tertiary syphilis and occurs about 10 to 15 years after the primary infection, most commonly between the ages of 30 and 50. It occurs in only a few of the people infected with syphilis — probably in less than five per cent — an incidence suggesting that a special type of Treponema *pallida* is responsible. It is much more common among men than women. It may be combined with tabes dorsalis in a disease called taboparesis. It can occur as a congenital condition in a congenital syphilitic. The disease is now much less common than it used to be, probably as a result of more effective methods of treating syphilis in its early stages.

The onset of the disease may be insidious extending over several months or dramatically sudden, appearing in a few days. The course of the disease can be described in three phases: an early phase, a middle phase and a late phase.

Early Phase

In this stage the patient begins to show evidence of developing dementia associated with neurological changes. Characteristically, the dementia shows itself in a change of the personality for the worse. The affected person becomes careless and inattentive, makes foolish decisions, cannot concentrate, is easily tired, cannot express his thoughts clearly and is obviously not the man he was. In mood he may be euphoric or depressed, easily moved to laughter or to tears. An admirable account of the progress of the disease is given in Steegmuller's life of de Maupassant who died of it. The patient may have headaches; his fingers become tremulous; he cannot pronounce words correctly. The tone of his muscles becomes reduced, the reduction showing in his face by a loss of the normal folds. His tendon reflexes are commonly exaggerated. His pupils become unequal and show the Argyll Robertson abnormality of loss of reaction to light without loss of reaction to accommodation. He may begin to have epileptic seizures.

Middle Phase

In the middle phase of the illness the dementia progresses further to gross personality changes, a severe loss of memory, crass errors in judgment and loss of normal control. Progressive dementia without mood change is common. About one patient in five is grossly euphoric and exhibits delusions of enormous wealth, cleverness or power: he is a millionaire, he has mountains of gold, he is the strongest man in the world, he has invented the most marvellous machines. A few are depressed, anxious and tearful. Some may alternate between euphoria and depression. Delusions of persecution may develop. Speech becomes even more disordered and more epileptic attacks may occur. Signs of paralysis become increasingly obvious. The patient cannot walk a straight line or stand on one leg. He develops a severe tremor of hands, lips and tongue. He may develop a paresis.

Late Phase

In this final phase the patient becomes markedly demented and incapable of rational thought and speech. Emaciation, physical weakness and muscular paralysis are severe. He becomes bedridden, cannot control his sphincters,

Dr. Gibson is a psychiatrist at St. Lawrence's Hospital, Caterham, Surrey, England. This is the fifth of a series of articles on psychiatric subjects.

is very likely to develop bedsores. Eventually he dies.

The outlook for the untreated disease is always bad. Death ensues within two or three years. In some patients a spontaneous remission may check the progress of the disease for some months, but relapse is almost always inevitable. With modern methods of treatment the late phase hardly ever occurs.

The diagnosis of the disease is made on the basis of a history of syphilis, the development of dementia, characteristic changes in pupils and reflexes, a positive Wasserman reaction of the blood, characteristic and diagnostic changes in the cerebrospinal fluid in which the Wasserman reaction is positive, the number of cells increased, the amount of protein and globulin increased, and the Lange curve shows the paretic type, e.g. 55543210000.

Taboparesis shows characteristics of both general paralysis and tabes dorsalis. It runs a much more chronic course than general paralysis and lasts for years. The dementia is commonly of the simple kind. The signs and symptoms of tabes include:

lightning pains — sudden attacks of severe pain in the legs or other parts of the body; visceral crises in which a cute pain and disorder of function occur in organs such as the stomach, rectum and bladder; ataxia with the feet lifted too high in walking and slapped down; blindness due to optic atrophy; loss of sphincter control; loss of tendon reflexes; irregular pupils; perforating ulcers of the feet and Charcot's joints, that is joints which are painlessly enlarged and disorganized.

Congenital General Paralysis is an uncommon development of congenital syphilis. Symptoms develop in adolescence and are similar to those developing in the adult variety. The grosser euphoria and depressive forms do not often occur. The typical picture is that of a gradually progressing dementia.

Treatment

The prognosis for patients with general paralysis of the insane has changed dramatically. This was accomplished first by the discovery of malaria treatment and more recently through the use of penicillin, which is now the treatment of choice. It is very important that treatment should begin as early as possible and before irreparable dementia has been produced.

Penicillin should be given first. After giving small doses for one day to detect unusual responses, it is given daily in doses of 60,000-1 million units until 12 million units have been received. This course may be enough to create a cure and abolish symptoms. Progress may be checked by examination of the cerebrospinal fluid, especially the cell count which, in a cured case, should return to normal. The cerebrospinal fluid should be examined at six-month intervals for one year and then once a year for five years. If there is any relapse the course of penicillin may be repeated.

Malaria treatment is as effective as penicillin but it is much more difficult to perform and has an element of danger. The patient is given an intramuscular injection of 3 cc. of blood infected with the organism of tertian malaria and is allowed to have eight bouts of fever of at least 103°F. The malaria is then controlled by administration of an antimalarial drug such as quinine sulphate. Attacks of malaria do not recur after this treatment.

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* * *

A wrong doer is often he that has left something undone, not always he that has done something. — TERTULLIAN

Infantile Eczema

ELLEN JOHNSON

Few patients exhibit the utter misery of the one with the extensive, angry, itchy eruption of eczema. Treatment is so often a practical application of the old adage: "If at first you don't succeed . . ." Fortunately, this method is frequently successful.

ALTHOUGH medical science has come a long way since the invention of the stethoscope or the discovery of insulin, there are still many hills unclimbed and many phases which lend a challenging, stimulating aura to the profession. What factors in the tissue suddenly cause a normally healthy person to produce new growths, or what constitutional factors suddenly cause a bounding, healthy child to become covered with angry skin eruptions? Of all the puzzling diseases that have been troubling pediatricians for years, eczema is probably one of the most dramatic and most interesting.

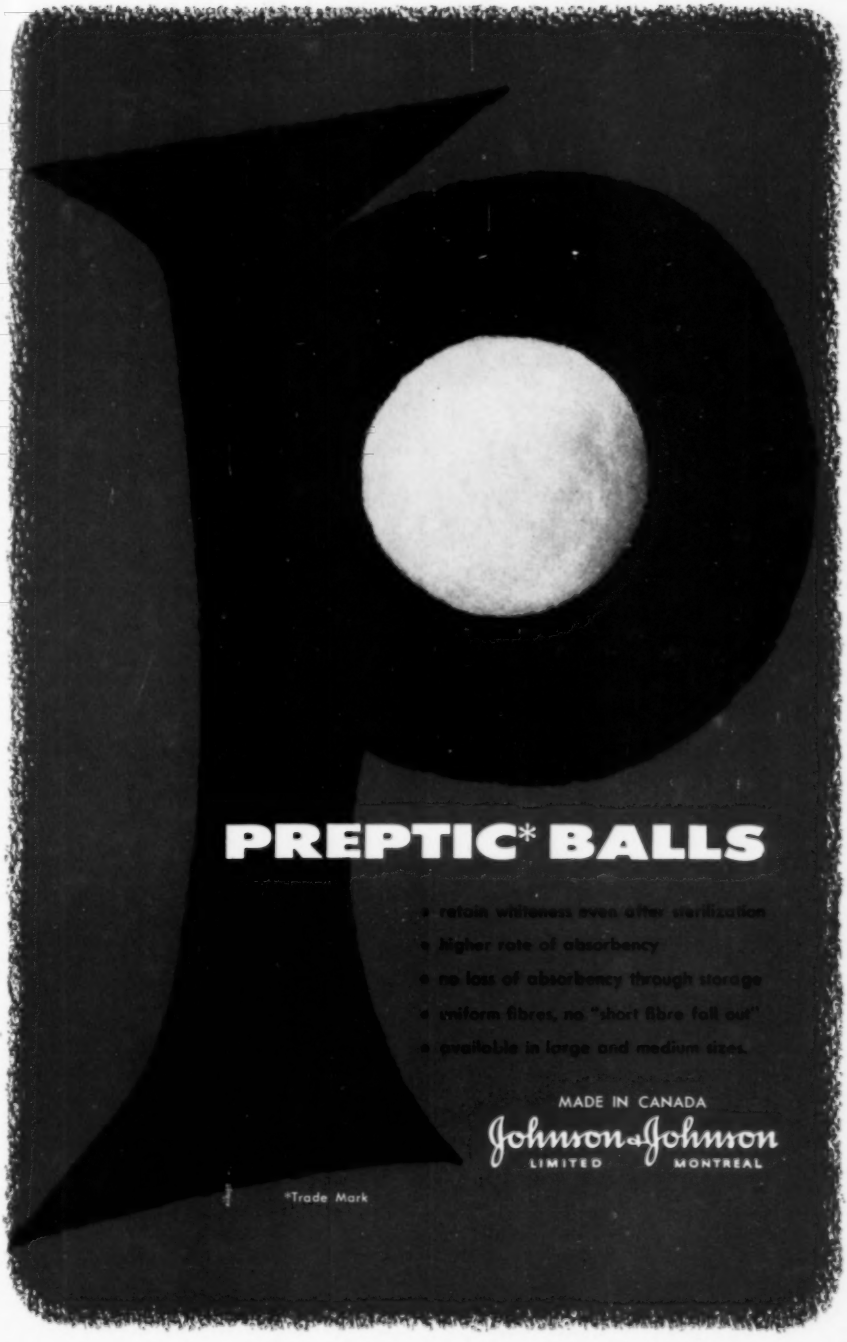
Eczema is a relatively common condition of infancy and childhood, often characterized by a reaction of the skin which in most cases has an allergic basis. It causes a great deal of discomfort to the child, and produces much anxiety in the parents. In severe cases, the entire skin surface may be involved, but the most frequent locations are: the cheeks, the scalp, and the folds of the skin — behind the ears, in the neck, axillae, and groins. The disease often commences with a reddening and itchiness of the cheeks, then spreads to other parts of the body. Although eczema is a relatively common condition, its appearance usually provokes numerous problems, many of which may be peculiar to that individual alone. This necessitates a deep understanding of the child's needs emotionally as they relate to this particular disease.

In order to gain an adequate knowledge of a child's emotional and physical background, observation of the parent-child relationship is essential, coupled with personal interviews. Unfortunately, in many hospitals the restrictions on visiting on pediatric wards make adequate parental contact almost impossible. Our knowledge of a child's home environment must be developed chiefly through keen observation of the child, telephone conversations with the parents and information gathered from charts.

When Daniel's parents brought their small, very ill, nine-month-old into our children's ward, his condition was enough to arouse a rather illogical though thoroughly understandable opinion of the parents in the minds of the nurses. The screaming, red-skinned, revolting-appearing baby had made his debut into the field of allergic diseases irrespective of nurses' opinions or the seemingly ineffective parental care he had received. His mother appeared to be a slightly overwhelmed, and rather frightened person of average economic status. She said that the disease had progressed so rapidly that before she had a chance to adjust to her child's changing condition, she suddenly realized that he was seriously ill and should be hospitalized. Later, we learned that about one month prior to his admission to hospital, Danny had been moved from a bedroom that he had previously occupied with his parents, to one that was freshly papered and painted. When questioned about Danny's response to this move, his mother said that she had not noticed any apparent physiological or psychological reaction.

About two weeks later the baby developed dry, red, scaly eczema on the buttocks that spread to the extremities and finally to the body trunk. The condition seemed to become worse after the child had worn a new nylon play-suit. Although Danny had

Miss Johnson is a senior student at Sarnia General Hospital, Sarnia, Ontario.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had no previously known allergies, the mother realized that an allergic condition was present in this sudden skin condition. She said that she had had several bouts of mild skin reactions when she was a child.

On consulting a doctor the mother was told to try eliminating a great many foods such as vegetables and meats. During this time, not knowing what she could safely give her child, she fed him a great many fruits, to many of which by skin tests later he developed a positive reaction. Upon admission to hospital, Danny's severely eczematous condition presented us with four major nursing care problems namely: diet, identification of allergic factors, skin care, and emotional care.

Diet

To patients suffering from eczema, the identification and elimination of the allergic factors, and the establishment of a proper diet are the gateways to success or failure, especially during childhood. Danny presented a problem in this regard even on a diet restricted to Mulsoy and rice cereal. For about a week his skin showed very little improvement. Mulsoy formula is made of water and a powder of a soy bean base. It is a fairly viscous formula, so was quite easily tolerated by the child at first. This was supplemented with rice cereal, which is light, easily tolerated, and seems to be responsible for few allergic reactions. Danny did not gain weight on this diet, so it was obvious that he would have to be given other foods, especially as he eventually started to vomit his Mulsoy feedings. He could tolerate small amounts given frequently and could drink this from a cup.

After Danny's skin started to improve a little, it was decided he could be placed on an *elimination diet*, in which only one new food is added to the diet at a time. After a new food has been given, the skin is watched carefully for two or three days for signs of a reaction. If no change occurs or if the skin seems to be improving, it is safe to continue giving this food and another new food may then be added. If, however, the skin becomes rough and reddened or in other ways shows an unfavorable reaction to the new food, the child is considered allergic to that food and it is automatically omitted from the diet. Using such a system it is necessary that each person caring for the patient is fully aware of what foods are permitted. A careful list of the foods to which Danny had been satisfactorily introduced was made out and posted in order to prevent mistakes.

Allergic Factors

With the fulfillment of the dietary needs, Danny's skin improved to such a degree that it was possible to do skin tests of 16 different foods. In a skin test, a solution containing protein from the allergen is injected subcutaneously. A careful observation for elevation or redness of the area is made a few minutes later. The nurse's responsibility is first to prepare the child as much as possible beforehand. With a nine-month-old child, this is rather difficult, but the presence of someone with whom he was familiar seemed to help. The nurse should also gently restrain the child with her hands using as little force as possible. It is her responsibility to write down a list of the allergens tried, in the order and formation in which they were injected.

The first skin test was rather unsuccessful as his skin was still too reddened. A later one was tried which proved much more successful and corroborated some of the facts which we had learned from his elimination diet. We could then use the results of the skin test as a basis upon which to build our basic diet.

Before Danny was discharged we tried to teach his mother a few simple principles for eczematous children which could be easily carried out at home. We gave her a list of the foods to which Danny's skin seemed to be negative, indicating which foods had already been tried and could safely be continued. We encouraged her to try new foods, but impressed upon her that only one new food could be tried at a time. We tried to make her as familiar with Danny's diet as possible, in order to prevent frustration on her part which could result in establishing poor feeding habits for Danny. Finally, we told her that if a redness or irritation did occur, she should consider the foods which he had eaten the day before and eliminate any

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doubtful ones. If the condition persisted she should, of course, notify the doctor.

Care of the Skin

The second, seemingly formidable problem, was care of the skin. The most important factor was the application of medications. Before anything was applied the skin was cleansed with a heavy, white, soothing, emollient liquid, the main ingredients of which were lanolin and olive oil. A small amount of the preparation was absorbed during application and the remainder, which contained debris encrustation and sloughed tissue was patted off, using a piece of scorched linen to prevent friction. After applying the preparation, Danny's skin was more soft and pliable. We then applied a thick, dark gray, tar-like paste made of a water-miscible base with zinc oxide and titanium dioxide as the two main ingredients. This not only provided a protective layer over the eczema, but also removed some of the dry, scaly, sloughed tissue from his skin. His cheeks were persistently very reddened and hardened, so a smooth white cream containing polyethylene glycol and propylene glycol was applied to them. This cream, which suppresses allergic dermatoses and skin reactions and decreases pruritus, made his cheeks smoother and softer. Danny's groins and genital areas were very slippery and red. Lassar's paste, which contains a zinc base and is heavier and more tenuous, was applied to these areas. This paste causes the cells to contract making the skin harder and less slippery.

After using the glycol preparation on Danny's cheeks for some time, it was discovered that they were healing up faster than the skin on the rest of his body. Accordingly, the doctor ordered the glycol preparation to be applied to his entire body. This preparation is applied very sparingly and only after the skin is first cleansed with the lanolin. Using this treatment the skin cleared up to such an extent that only the area around his external genitalia remained hardened, elevated, and reddened. Scrapings were taken from the area, and tested for fungi, but the results were negative. Eventually, with use of a controlled diet, proper cleansing, and the application of the glycol preparation, this area, too, cleared up.

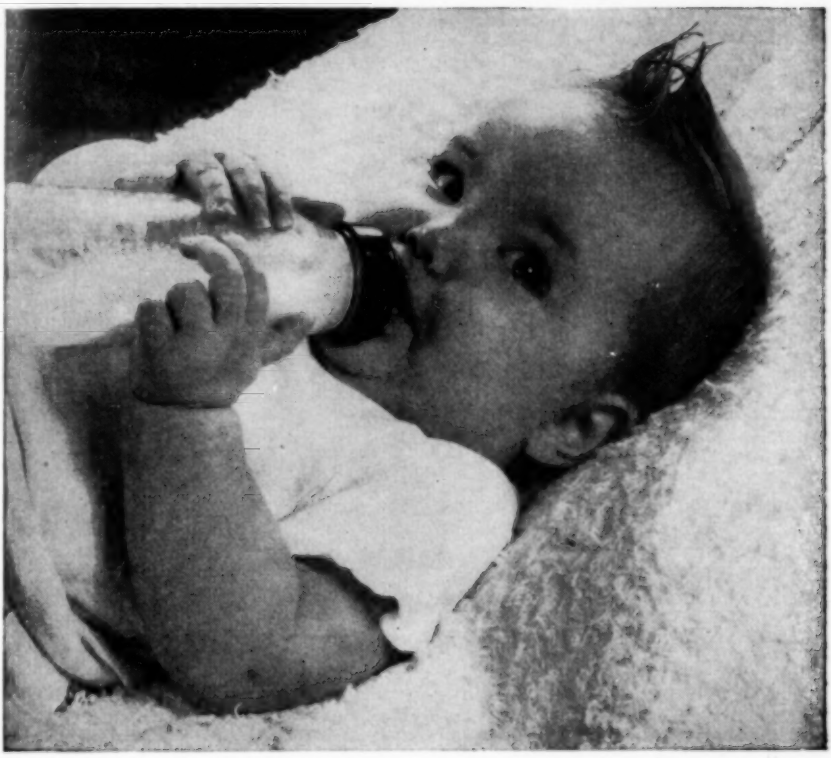
Scorched linen is especially effective in conditions such as Danny's because all the lint is removed in a hot oven and provides a soft, non-irritating covering for the tender eczematous skin. Danny's bed was made up using the same kind of linen so that even the bed clothes could do little to irritate his sensitive skin. When giving him his skin treatments, especially during the acute stages of the disease, it was usually better to expose only small areas of the skin at a time. Because his skin was very itchy, he could usually manage to scratch it or rub it in some way, in spite of our efforts, if large areas were exposed at one time. Even a very small scratch would bleed and make his skin even more itchy and irritable. After the skin started to improve, at least half of his body could be exposed at one time.

A stockinette mask with eyes, nose, and mouth cut out, was pulled over his head to protect his cheeks from the bed linen. Danny loved to sit up in a high chair for part of the morning each day. It was not necessary for him to have the stockinette on at this time.

Unfortunately, Danny's condition was such that it was necessary to restrain him with elbow splints. These were put on over the dressings and were removed twice a day for short periods. They could be removed only under supervision lest Danny should find some way to scratch himself. They were padded at both ends to prevent irritation of the skin from pressure. After all the linen dressings were applied and the splints put in place, stockinettes were pulled over arms and legs, and pinned to the diaper. The principle of using splints is to allow the child plenty of movement from the shoulder joint and yet prevent purposeful movements of the elbow joint.

On discharge, some teaching of skin care was necessary in order to extend the doctor's plan of treatment. To cleanse the skin, it was necessary to point out a few facts to the mother. Danny could not have either tub or shower baths until permission was given by the doctor. A very gentle

He's happy! . . . he's on S-M-A!



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sponging with tepid water using no soap seemed best. We tried to emphasize the fact that his skin should be patted dry as rubbing would very easily irritate it. The mother was given a tube of a cortisone preparation to use at times when areas seemed to be becoming eczematous again.

Emotional Behavior

That Danny's disease was closely linked to his emotional behavior was evident almost from the beginning. At first he seemed to be like any other very ill little boy. He was irritable, took his feedings only with persuasion, and cried violently when disturbed for any reason. After the more acute phase of his disease was passed, Danny still produced evidence of emotional upset. He made shrill, irritable crying noises very frequently, often when apparently quite happy. Sometimes he would sit in one position for quite a while and seemed irritable and hypersensitive to any unusual stimulus. Danny needed some one person to cuddle him and form a rather close, personal relationship with him. His condition alone must have caused the very height of frustration without having the feeling of being rejected by those who cared for him added to it. Although a nurse often feels guilty because of the repulsive effect a child such as Danny has upon her, such feelings are natural. By regarding the situation in this light and thus bringing about a deeper understanding of herself and her relationship to the child, the nurse can give him better and more satisfactory care.

Aside from personal relationships, Danny's frustration could have other outlets. Some of it could be lessened by removing his splints as often as possible and by taking off his face mask for a period each day. Sitting in a doorway in a high-chair seemed to provide a maximum of enjoyment for him, so we tried to work this pleasure into his plan of care at least three times a day. He was a very playful little boy so we provided him with several bright, noisy toys.

Before he was discharged, possible emotional problems were reviewed with the parents. Danny was an only child so the attitude of the parents towards him in comparison with other members of the family did not present a problem. However, he seemed to be such a sensitive child that overprotection or even a slight amount of rejection could warp his character. Talking in a matter-of-fact, kindly way to the parents helped them accept and understand.

Danny's growth and development seemed slightly advanced for his age. The anterior fontanel appeared to be closing. He drank from a cup without much spilling. He was partially toilet-trained on admission, but during his illness, he regressed to the point where he was usually incontinent. The linen wrappings and the general frustration from his condition may have been partly responsible for this. Danny crawled around his bed well, and towards the end of his hospitalization, started making attempts to pull himself to his feet. Like most nine-month-olds, he feared strange things or people. For example, he cried violently when placed on the scales or when a strange person entered the room. This apprehension may have been a product of his disease, to some extent, because as his condition improved, his fears became less and less evident. He loved to watch any movement in the room, especially another baby being bathed. He would laugh merrily if a baby made gurgling noises. Danny could handle large toys quite well with his hands. He could grasp a toy or rattle, and shake it expertly.

While caring for Danny, our many challenging problems and our fight for progress instilled in my mind a knowledge of the disease which will undoubtedly prove of infinite value to me in the future.

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Missionary Nurse

MABEL JOHNSON

Combining the positions of director of nursing, nursing instructor and operating room supervisor for a 40-bed hospital would frighten most of us. These, however, are some of the responsibilities of a Canadian nurse in Portuguese West Africa.

IT was Christmas Eve, 1957. We had just finished a lovely evening with one of our missionary families when a message from the hospital arrived. Amelia Baptista was in labor. In a few hours I had the joy of delivering her of twins — both breech presentations. Relatives usually crowd into the waiting room or corridor and what rejoicing, clapping and dancing goes on when a little one — or even twins are born!

Catota Memorial Hospital

How different this scene was some 25 years ago when missionaries first arrived at the Catota Mission Station, in Angola, Portuguese West Africa. No hospital, no nurses, only African midwives working in villages in unsanitary surroundings, with resultant high mortality rates. The Africans of that area are animists and live in fear of evil spirits. If twins were born, surely one possessed an evil spirit, so both would be buried alive. What a transformation has been wrought! Amelia has been a keen Christian for years and now twins bring joy instead of fear to her and to many others.

Early in 1948, Dr. and Mrs. A. C. Henderson of Toronto arrived at Catota. They began building a 30-bed hospital so Dr. Henderson's medical skill was laid aside part of each day in order to supervise the building program which included the making of burnt brick, roof tile, hauling rock, sand etc.

In November, 1948, I arrived, after spending a year studying the Portuguese language in Lisbon, Portugal. My first five months at Catota were spent mainly in learning Nyemba, one of the African languages of that area. I also spent some time in our small three-roomed dispensary and every day we watched the progress in the construction of our new hospital.

In 1949 the operating room and a few other rooms were completed so we transferred our equipment from the clinic to our new hospital. Patients were flocking in for treatment — badly burned cases, malaria, relapsing fever, pneumonia, tropical ulcers, elephantiasis, schistosomiasis, ameba, anquilostome, tenia, etc. They all needed treatment. Surgical cases also came pouring in and in a few weeks about 40 patients with thyroids, some medium, many huge, came to ask if the doctor couldn't help them. No one seemed afraid of surgery. To them the surgeon's knife could work miracles.

We worked hard getting our operating room ready, sewing laparotomy sheets, drapes, gowns, etc.; washing scrubbing and sterilizing. We had no stove to begin with, so the African masons made an outdoor stove of brick with a round drum cover for the top. If we fed it sufficient dry wood we managed to get our sterilizing done! How we appreciated our "real" stove when it arrived from Cape Town.

Soon our doctor was doing all kinds of surgery — hernias, hydroceles, removal of huge abdominal tumors, thyroidectomies, hysterectomies, excision of breast lipomas (one weighed almost 12 lbs.), cataracts and even spinal

Miss Johnson is at Catota Memorial Hospital, Angola, Portuguese West Africa.

fusions. All this with only one doctor and two nurses!

Hyperthyroidism

From the beginning we realized the necessity of training African nursing assistants. Our first two students, Edwardo Jacob and Herculano Chico, graduated in 1952 and since then over 20 students have completed the three-year course and have received their diplomas. All our students receive a three-month laboratory training. After nurses' graduation, Mr. Edwardo Jacob took postgraduate work and is now in charge of our laboratory. He is very capable and helps in our teaching program. Nurses also have three months in the pharmacy and some time at our leprosarium where we have over 100 patients. Mr. Herculano Chico is now in charge of the operating room and is a very conscientious worker.

Our medical work was growing so quickly that our hospital with its five rooms for clinic was soon too small so we began building a new outpatient department. This was completed last year. We now have room for about 40 beds in the hospital. We have about 125 to 150 patients who come daily for consultation or treatment and our prenatal clinic has about 30 in attendance every Friday. A few years ago only the ones who were having difficulty came. We will soon need a maternity hospital but that may take a long while to materialize as we receive no grants for our work. It is maintained by the free will gifts of churches and folks in the homeland who realize the value of such work.

In 1953 Dr. and Mrs. Henderson and their two children went home on furlough and were unable to return for health reasons. Dr. Regina Pearson was with us for three years and is now in charge of the large leprosarium at Cavango in Angola. We were without a doctor for about two years. Our nearest mission hospital with a doctor was at Dondi, about 175 miles away.

Even though we were without a doctor patients kept flocking in as before. We treated a number who had been mauled by leopards and lions. One was carried by stretcher for three days and by the time he arrived we could smell the gas gangrene even before the wounds were uncovered. He responded well to treatment. He came to greet us at camp last year, and to thank us again for help received.

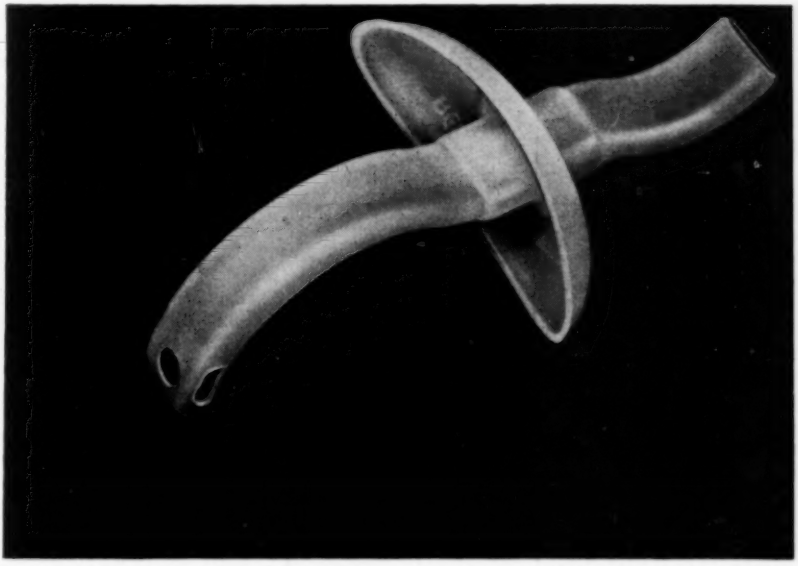
Miss Johnson and Native Nurses

One day a five-year-old lad was brought in with "bloody diarrhea and abdominal pain." There was no evidence of diarrhea when he was admitted but his spasmodic pain continued and on palpating his abdomen we found he had a small moveable "growth." After pouring over medical books we diagnosed "intussusception." We would have to take him to Dondi immediately. We began our journey over rough roads early in the morning and after a few car difficulties along the way, finally arrived at 7:00 P.M. I gave the anesthetic, the mission doctor operated, assisted by his nurse. The invaginated bowel was dealt with and circulation brought back to the reddened area. The boy's life had been saved and the parents were grateful

to all for his speedy recovery.

These two "doctorless" years were busy, full of interest and varied experiences. However, the responsibilities were heavy and we were very glad last year when Dr. Lois Roberts from California arrived just before I left for furlough and home.

I returned to Angola last autumn and am looking forward to teaching a new group of students, to supervising our 40-bed hospital and operating room. The only other missionary nurse left for furlough when I returned so there were responsibilities in the outpatient department and leprosarium. However our graduates have taken over a great deal of responsibility; without them we could not carry on. It is a joy to see them as concerned about the spiritual needs of their patients, as they are about their physical needs. We seek to minister to the patient in his every need of body, soul and spirit. Healed bodies, lifted spirits and transformed lives make us feel that this work is worthy of all we have to give.



A simple new "breathing tube" for artificial respiration has been announced by Johnson & Johnson Company. Called *Resusitube,* the device is said to be far more effective than any manual method of artificial respiration now in use. It is based on the technique of mouth-to-mouth breathing.

Its uses include: victims of drowning, electric shock, smoke or gas inhalation, drug or chemical poisoning, cardiac arrest, brain injury and shock from blood loss. It is a pocket-sized, S-shaped tube of translucent white plastic. One end acts as a mouthpiece for the rescuer who is stationed at the victim's head. The other end, inserted over the victim's tongue to its base, provides the breathing tube. The rescuer's hands are free to keep the patient's head tilted back and his chin upward. This is vitally important in maintaining an open airway since the passageway is blocked when the patient's head is bent forward. The device is fitted with a flange to prevent air leakage.

Mouth-to-mouth (or expired air-resuscitation) has been widely tested and is now an approved life-saving procedure. The Resusitube makes mouth-to-mouth breathing easier, more effective and more acceptable by eliminating the need for direct oral contact with the victim. In both controlled studies and actual emergencies, it has proven more efficient in maintaining an open airway and providing pulmonary ventilation, and less fatiguing to the rescuer than manual methods.

The tube comes in two sizes, one for adults and children over 3 years; the other for younger children and infants. The retail price is $1.50 for each size.

In Memoriam

Muriel (Young) Aiken, who graduated from The Toronto Western Hospital (formerly Grace Hospital) in 1930, died on June 26, 1959. She had engaged in private nursing for several years prior to her death.

* * *

Adeline (Racicot) Cloutier, a graduate of the St. Charles Hospital, St. Hyacinthe, Quebec, in 1929, died at Sorel, Quebec on September 19, 1959.

* * *

Rachel Drouin, who graduated in 1944 from the St. Vincent de Paul Hospital, Sherbrooke, Quebec, died in September, 1959.

* * *

Claire (Noël) Ducharme, a graduate of the St. Vincent de Paul Hospital, Sherbrooke, Quebec, in 1942, died in September, 1959.

* * *

Catherine Graham, who graduated from the Victoria General Hospital, Halifax, in 1895, died in that city on September 30, 1959. She was a charter and life member of the RNANS and had served overseas in World War I. After the war she joined the staff of the Department of Health and Welfare of the City of Halifax, where she served until she retired in 1953.

* * *

Marjorie Jean (Kirker) Jarrett, a graduate of the Cornwall General Hospital, Cornwall, Ontario in 1951, died on July 3, 1959. She had been living in Rockford, Michigan and was employed in institutional nursing.

* * *

Catherine (Page) Smith, who graduated from The Toronto Western Hospital, in 1931, died on July 11, 1959, at Soldiers' Hospital, Orillia, Ontario. Following several years in institutional nursing, Mrs. Smith was the industrial nurse at Standard Brands Company Toronto until her marriage.

Jane Broadfoot MacLelland, a graduate of Soldiers' Hospital, Orillia, Ontario, in 1922, died on November 1, 1959. She had been engaged in private nursing.

* * *

Alexina Marchessault, who graduated from the Hotel Dieu Hospital, Montreal in 1918 died in October, 1959. She spent five years in the nursing services of Metropolitan Life Insurance Company, following which she joined the teaching staff of the School of Public Health of the University of Montreal. From 1934 to 1940 Miss Marchessault was director of this school. Latterly, she was employed in the Division for the Handicapped, of the Unemployment Insurance Office in Montreal.

* * *

Jessie Bell Monkman, who graduated from Lamont Public Hospital, Alberta, in 1918, died in Toronto, October 7, 1959. She had been engaged in private nursing in Toronto.

* * *

Daisy Evelyn Munnings, a graduate of the Hamilton General Hospital in 1934, died recently. She had been engaged in occupational health nursing.

* * *

Sister Jeanne Phaneuf, a 1921 graduate of the Hotel Dieu Hospital, Montreal, died in that city in November, 1959.

* * *

Florence Tait, who graduated from the Cornwall General Hospital, in 1938, died suddenly on August 13, 1959. Since 1952 she had been on the staff of Women's College Hospital, Toronto.

* * *

(Mrs.) Maureen E. Watson, died recently in Ontario. She graduated from St. Paul's Hospital, Vancouver, in 1954, and had been engaged in institutional nursing.

The sense of humor is the just balance of all the faculties of man, the best security against the pride of knowledge and the conceits of the imagination, the strongest inducement to submit with a wise and pious patience to the vicissitudes of human existance. — Richard M. Milnes

* * *

The whole art of teaching is only the art of awakening the natural curiosity of young minds for the purpose of satisfying it afterwards. — Anatole France

Words are like leaves; and where they most abound, much fruit of sense beneath is rarely found.

— Pope

* * *

The highest possible stage in moral culture is when we recognize that we ought to control our thoughts. — Charles Darwin

* * *

It is futile to expect a hungry and squalid population to be anything but violent and gross. — Joseph Priestley

POSEY PATIENT SUPPORT

Patent Pending

The Posey Patient Support was designed to fill a long-felt need. It is used on wheelchairs or conventional chairs. It is possible to get a bed-patient up into a chair with safety and with no fear of danger. Generously designed to accommodate practically all size patients and all types of chairs. Available in small, medium and large sizes in two models. Standard Model, Cat. No. PP-753, $6.75 each. Adjustable shoulder strap model, Cat. No. PP-154, $7.50 each.

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FIVE OF EIGHT

Though the shortage of nurses is a recurrent problem in many areas, one family has made a notable contribution toward meeting this demand. Mrs. Worrell and the late R. W. L. Worrell, formerly a conductor on the Canadian National Railways, had eight daughters. Between 1935 and 1952 five of these young women graduated from schools of nursing. Robina, Jean and Beatrice chose the Soldier's Memorial Hospital in their home town of Campbellton, N.B.; Elsie went to the Civic Hospital in Ottawa; Rachel, the youngest, enrolled at Royal Victoria Hospital, Montreal.

Two of the sisters are still active professionally though all five have married. Robina, Mrs. R. Day, is on the staff of the Outpatient Department at the Reddy Memorial Hospital, Montreal. Rachel, Mrs. R. W. Fitzgerald, is on the staff of Victoria Hospital, London, Ont. Elsie, Mrs. J. L. K. Marais, is residing now in Cape Town, South Africa. Beatrice, Mrs. S. C. Douglass lives in El Paso, Texas. Jean, Mrs. A. B. Lovelace of Lennoxville, Que. completes this family of nurses.

ROBINA JEAN BEATRICE ELISE RACHEL

Phase II to be Launched

Since June, 1959, the Canadian Nurses' Association has published its official nursing journal in two languages. Despite a few inevitable problems that accompanied the translation of editorial material from either language to the other, the new issue *L'Infirmière Canadienne*, has been well received. Genuine satisfaction with the *Journal* in their native language has been expressed by countless subscribers.

Phase I in this developing program covered the publication of an essentially identical *editorial* content. Phase II provides for the translation of *all the advertisements* that are included in the section of the *Journal* headed "Employment Opportunities." In addition, postgraduate courses given either in hospitals or in universities will also appear in both English and French. A new scale of rates for these dual-language advertisements has been approved by the Journal Board on behalf of the Canadian Nurses' Association. These new rates become effective with the February, 1960 issue. All organizations utilizing the *Journal* for advertising purposes during the past two years were notified last November of the beginning of Phase II.

The rates for line advertisements (classified) will be as follows:

Canada and Bermuda
Three lines or less —$7.50
Each additional line — $1.50
United States and other foreign countries
Three lines or less — $10.00
Each additional line — $3.00

The rates for professional display advertisements that are placed with the Journal directly by an organization are available on request. No discounts or commissions are allowed on these insertions.

All professional advertisements placed through or by an advertising agency will be charged at the commercial advertising rates appearing on the *Journal* Rate Card No. 8. Fifteen per cent agency commission and 2 per cent discount for payment within 30 days of the date of invoice are allowed on these insertions.

All translation costs will be borne by the *Journal*.

International Pediatric Study Tour

This tour was sponsored by the National Council of Nurses of Great Britain and Northern Ireland and the Association of British Pediatric Nurses. The course was held in London, May 3-11, 1959. Seventy-six participants attended and the group included nurses from Australia, Canada, Denmark, Finland, Eire, Germany, Great Britain, Holland, Sweden, Switzerland, Northern Ireland and the United States.

Three Canadian nurses were present — Rosemary Prince, Saskatchewan, Dorothy Richards, Ontario, and Phyllis Lyttle, Nova Scotia. Miss Prince and Miss Richards are graduates of the School of Nursing, University of Toronto, and had been working in one of the London, Eng. hospitals for several months.

The course proved to be most interesting and worth while. Some of the lectures included: family responsibilities; care of children outside of hospital; pediatrics today and the pediatric nurse; care of children in hospital; new diseases; early diagnosis and treatment of cerebral palsy. In addition we visited hospitals, pediatric units, health units, day nurseries, etc.

One afternoon we were privileged to visit either the Royal College of Nursing, the National Council of Nurses, or the International Council of Nurses. Miss Bridges, of the International Council of Nurses, was extremely interested in having us as her guests. Included in the general itinerary was a tour of London and a trip to Cambridge.

On our last night in London we were guests at a dinner in the Dorchester Hotel. Our hosts were the directors of Cow and Gate, Ltd. Each group had a leader who knew London, thus we did not have too many difficulties on the buses or tubes. Miss Rowe, of the National Council of Nurses of Great Britain and Northern Ireland, and Miss Lane, of the Association of British Pediatric Nurses, were extremely kind and helpful.

PHYLLIS J. LYTTLE, R.N.,
Superintendent of Nurses,
Dept. of Public Health.

Book Reviews

The Care of the Patient in Surgery including Techniques by Edythe Louise Alexander, R.N., B.S., M.A. 840 pages, 555 illustrations. C. V. Mosby Company, St. Louis, Mo. 1958. Price $12.75.

Reviewed by Mr. Ralph Coombs, Operating Room Supervisor, University of Alberta Hospital, Edmonton, Alta.

This is a comprehensive text covering every phase of operating room nursing from planning a new operating suite to instructing those people who are to work within the suite. The author has made every effort to assist the nursing members of the surgical team to provide and maintain a safe environment for the surgical patient.

The first section of the text discusses the new operating room, what it should be like and what it should contain. Basic principles of asepsis are well discussed in concluding the section. This portion of the book is of considerable value.

The concluding chapters give a comprehensive coverage to the surgical specialties. Each chapter begins with a review of the anatomy and physiology that is essential to the understanding of that particular type of surgery. This is complemented by a discussion of the basic instruments commonly used by that service, the operative position or positions used and a step-by-step account of some of the more common operations.

This book is well written, concise and thought-provoking. All those interested in broadening their nursing experience in the operating room will find it of great value. Every hospital library should contain a copy.

Education for Nursing Service Administration by Mary Kelly Mullane, R.N., Ph.D. 242 pages. W. K. Kellogg Foundation, Battle Creek, Michigan. 1959.

Reviewed by Miss Dorothy Hibbert, University Hospital School of Nursing, Saskatoon, Sask.

In this book Dr. Mullane skilfully summarizes the accomplishments of 14 universities in developing and conducting programs in nursing service administration on both the Bachelor's and the Master's level of education. These programs were sponsored by the W. K. Kellogg Foundation over a five-year period, 1951-56. This book was also sponsored by the Foundation reflecting their philosophy of their obligation to eval-

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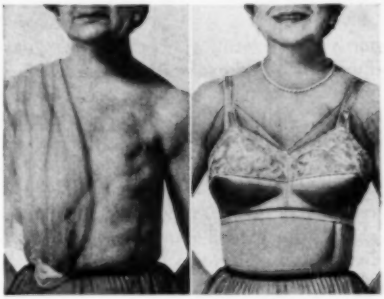

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uate and report the results of the programs that they sponsor.

The administration, faculty, students, curricula and research are each described in sufficient detail to provide an excellent guide for the development of similar programs. For example, the objectives of educational programs in nursing service administration are outlined; the desirable qualifications for faculty are listed; the learning experiences and the content of various courses are discussed; samples of questionnaires used to evaluate programs are included. In the final chapter the author raises penetrating questions for consideration in curriculum planning. On what basis should we determine the length of field work desirable? What will be the impact on nursing service in our general hospitals of having psychiatric units, and of giving progressive patient care? What should nursing service administrators be taught about overall hospital administration?

The author is to be commended for the readability of this report. She has compiled pertinent information about the various programs in a skilfull manner and in a style that will make enjoyable reading for nurses interested in curriculum development in the profession; a valuable guide for university faculties in developing similar programs and an important reference for graduate nurse educational programs.

Pharmacology and Therapeutics by Harold N. Wright, M.S., Ph.D. and Mildred Montag, Ed.D., R.N. 497 pages. W. B. Saunders Compauy, West Washington Square, Philadelphia. 7th ed. 1959. Price $5.00.

Reviewed by Miss Dorothy Wood, Instructor, Grace Hospital, Winnipeg, Man.

The authors had three main objectives in mind for this extremely readable and practical textbook.

1. To attempt to bring us abreast of recent advances in pharmacology and therapeutics.

2. To expand material concerning acid-base and electrolyte balance by a discussion of clinical acidosis and alkalosis and the parenteral use of the various solutions of electrolytes.

3. To discuss, for example, related drugs in connection with the care of the cardiac and hypertensive patient.

The text should be valuable to the student at all levels of her educational experience. The first two or three units deal with the basic material found in earlier editions as well as in most other texts: terminology, drug standards, sources, types of drug preparations. The arithmetic review and calculation of amounts of drug has been reorganized and restored instead of being published separately as in the last two editions. The Canadian as well as American drug legislation is discussed very well.

Illustrative material in the form of diagrams and tables should add greatly to the student's understanding, especially in particular areas such as "Drugs affecting the acid-base and water balance of the body." Bibliographies are to be found at the conclusion of each chapter. They have been revised and brought up-to-date. Included are references to several professional nursing journals. The journals chosen would be available in most schools of nursing.

After the basic material has been discussed the authors relate drugs in the care of patients suffering from various disorders. The patient-centered approach and the nurse-patient relationships are emphasized throughout. In discussing patients suffering from cardiovascular and hypertensive symptoms, there is a concise summary of normal physiology and then a comparison of the normal with the abnormal. Drugs are discussed in relation to this. The usual information concerning source, therapeutic usefulness, action, administration and dosage, toxic effects is given for each drug. The drugs most commonly used as part of the treatment for these patients as well as some newer preparations, are discussed: Digitalis and related preparations, quinidine, pronestyl, nitrites, rauwolfia, Diuril, anticoagulants. The physical and mental comfort of the patient is discussed in relation to some drugs, particularly digitalis. The student is thus made aware of the part that nursing care plays in drug administration.

The questions at the conclusion of each section make the student aware of her responsibilities in the administration of drugs, and of the function of the drug as a means of therapy for the individual patient.

This text appears to discuss the principles of pharmacology without going into too great detail. The student should find the book readable, practical, and as up-to-date as possible. The instructor should find it valuable in guiding her students in the study of pharmacology.

Applied Anatomy for Nurses by E. J. Bocock, S.R.N., S.C.M., D.N. and R. Wheeler Haines, M.B., D.Sc., F.L.S. 326 pages. The Macmillan Company of Cana-

da Limited, 70 Bond Street, Toronto. 2nd ed. 1959. Price $3.00.

Reviewed by Sister Clare Marie, Director, Nursing Education, St. Martha's Hospital, Antigonish, N.S.

This book treats anatomy from a regional point of view, unlike the usual exposition of systemic anatomy found in most texts. It is written in a very concise style, uncluttered by too much detail but adequate enough to give a clear understanding of the subject matter. The content is presented in a very vivid manner, especially planned to stimulate the process of association. This factor, supplemented by excellent diagrams makes the text a valuable teaching aid.

The sections dealing with muscles, both from a diagrammatic and explanatory point of view, are exceptionally well done. Various items stand out because of the manner in which they are elaborated upon, for example, the explanation of why arteriosclerosis is more prevalent in blood vessels of the brain than anywhere else in the body; the mechanism of the coronary sinus; the phenomenon of the closing of the foramen ovale.

Extraneous material appears here and there but the inclusion of it is explained by the authors when they say that they "make no apology for presenting a great variety of interesting facts, for only the student can select those she requires." Since it presupposes that the reader has a basic knowledge of anatomy, this book would seem to serve its most useful purpose as a reference text, both for instructors and students.

Physiology and Anatomy by Esther M. Greisheimer, B.S.Ed., M.A., Ph.D., M.D. 868 pages. J. B. Lippincott Company, 4865 Western Ave., Montreal. 7th ed. 1959. Price $6.00. (Videograf edition).

Reviewed by Sr. Capt. Ethel Kollin, Director of Education, Grace Hospital, Winnipeg.

The seventh edition of this text was first published in 1957. Although the context is unchanged, there has been a slight revision to allow for the inclusion of a "Videograf" section. This is composed of eight plates of transparent diagrams in color. They show body parts in relation to each other as the Videograf leaves are superimposed upon one another. The layers of the body may be seen from the anterior on the front of the plate and the posterior on the back. This is a worthwhile addition to the book and should prove of considerable value.

PRACTICAL APPROACH TO MICROBIOLOGY FOR NURSES

By Lida S. White and Sr. Sigrid L. Nelson, both of Lankenau Hospital, Philadelphia, Pa. A book of laboratory exercises for beginning students. 127 pages, 1959. $4.00.

UROLOGICAL NURSING MANUAL

By Alfred H. Rossomando. Mercy Hospital, Nampa, Idaho, and Florence M. Miles, Boise Junior College, Boise, Idaho. A manual for student nurses. 112 pages, 27 figures, 1959. $3.75.

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(5) Regional Superintendent, 4th Floor, Booth Building, 165 Sparks Street, Ottawa, Ontario.

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Registered General Duty Nurses (4) Certified Nursing Assistants (2) replacements for ones who have been married. For 105-bed hospital in a town of 15,000 population. Gross salary ranges from $210-$240 with annual increments. 3-wk vacation, 7 statutory holidays, Blue Cross medical/surgical participation, 14-day sick leave, no night duty except in Obstetrical Dept. 8-mi. from Camp Petawawa, 2-hr. from Ottawa & 4-hr. from Montreal with excellent train & bus service. Active, interesting community social life in the heart of the beautiful Ottawa Valley. Active Ski, Curling & Golf Clubs, also the home of the famous Pembroke Lumber Kings Hockey Team, 2 Theatres & a "Drive-In". Forward application to: The Director of Nursing, The Cottage Hospital, Pembroke, Ontario.

General Duty Nurses for an accredited 64-bed hospital. Starting salary: $250-$260, Good personnel policies with sick leave benefits, holidays & paid vacations. Apply Director of Nursing, Douglas Memorial Hospital, Fort Erie, Ontario.

General Duty Nurses for 100-bed hospital, up-to-date facilities in a beautiful location on the shore of Lake Erie. Salary $267 per mo. with recognition for P.G. courses, 40-hr. wk. effective January 1, 1960. Residence available. Apply: Director of Nursing, General Hospital, Port Colborne, Ontario.

General Duty Nurses (all departments) for 350-bed General Hospital, gross starting salary $255 per mo., 40-hr. wk. Apply to: Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

General Duty Nurses for all departments. New 250-bed hospital opening early in 1960 in the Niagara Peninsula. 5-day wk. with 3-wk. annual vacation. Residence accommodation available. Apply: Director of Nursing, Welland County General Hospital, Welland, Ontario.

General Duty Nurses Male & Female & Certified Nursing Assistants (Immediately) for 86-bed hospital, 40-hr. wk., 8 statutory holidays & other employee benefits. Collingwood is situated on Georgian Bay & is noted as a vacationland with 7-mi. sand beach along with great skiing on the Blue Mountains in winter. For further information apply: Director of Nursing Services, General & Marine Hospital, Collingwood, Ontario.

General Duty Nurses Excellent salary scales & personnel policies. Apply to: Director of Nurses, Parry Sound General Hospital, Parry Sound, Ontario.

McKellar General Hospital, Fort William, Ontario has openings in all departments for **General Staff Nurses.** Basic salary $270 per mo., 40-hr. wk. Good personnel policies for other benefits. Residence accommodation available. Apply to: The Director of Nursing.

General Staff Nurses (4) for convalescent area of 10-beds. Must rotate on all shifts, 8-hr. 5-day wk., good personnel policies, pension policy in effect., 3-wk. annual vacation, 8 statutory holidays. Salary open at present. Apply: Director of Nursing, General Hospital, Stratford, Ontario.

Public Health Nurse (Qualified) Position open in a completely generalized program. Salary range, pension plan & other personnel policies given on request. Applicant must have car. Apply to: Dr. W. H. Cross, Muskoka District Health Unit, Bracebridge, Ontario.

Public Health Nurse (qualified for generalized program) R.N.A.O. salary schedule in effect. Apply to: Director of Nursing, Fort William & District Health Unit, 900 Arthur Street, Fort William, Ontario.

Public Health Nurse (Qualified) for generalized program in Etobicoke Township (suburb of Toronto). Minimum salary $3,570, starting salary based on experience. Car allowance $670 per annum. 4-wk. vacation after 1-yr. Pension Plan, P.S.I. & Blue Cross benefits Apply: Director of Public Health Nursing, Township of Etobicoke, 550 Burnhamthorpe Rd., Etobicoke, Ontario.

Registered General Duty Nurses & Certified Nursing Assistants, Operating Room Nurse for 100-bed General Hospital in attractive town on Lake Huron. Good personnel policies. Apply to: The Director of Nursing, Alexandra Marine & General Hospital, Goderich, Ont.

SUBURBAN TORONTO

GRADUATE NURSES & CERTIFIED NURSING ASSISTANTS

Are invited to enquire re: employment opportunities in a well staffed new 125 bed hospital in suburban west Toronto. General duty salary range: $255-$305 per mo. Certified Nursing Assistants $190-$210 per mo. 5 day week. Residence accommodation optional. Personnel manual forwarded on request. Enquire to:

DIRECTOR OF NURSING, HUMBER MEMORIAL HOSPITAL, 200 CHURCH STREET, WESTON, TORONTO 15, ONTARIO — CH 4-5551

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FOR THE OPERATING ROOM, OBSTETRICAL AND MEDICAL SURGICAL UNITS OF A 350-BED GENERAL HOSPITAL

Gross salary $260 - $290 per month if registered in Ontario.
Differential of $10 for evening and night duty.
40-hour week. Sick leave cumulative to 30 days.
3 weeks vacation and eight statutory holidays.

Apply:

DIRECTOR OF NURSING SERVICES,
METROPOLITAN GENERAL HOSPITAL, WINDSOR, ONTARIO

GENERAL DUTY NURSES

FOR ALL DEPARTMENTS

Gross salary $276 monthly ($127 bi-weekly) with annual increment $10 monthly ($4.60 bi-weekly) for three years, if registered in Ontario; $256 monthly ($117.80 bi-weekly) until registered. Rotating periods of duty, 40-hr. per wk., 8 statutory holidays. 14-days vacation & 12 working days leave for illness with pay after 1-yr. Pension plan available. Ontario Hospital Insurance with Blue Cross supplemental & Physicians' Services Incorporated, partial payment by hospital.

APPLY

DIRECTOR OF NURSING, GENERAL HOSPITAL, OSHAWA, ONTARIO.

THE PETERBOROUGH CIVIC HOSPITAL

REQUIRES

NURSES FOR GENERAL DUTY IN ALL SERVICES.

For further information write:

THE DIRECTOR OF NURSING

PETERBOROUGH CIVIC HOSPITAL, PETERBOROUGH, ONTARIO

Operating Room Nurses for general operating room work which includes cardiovascular neurosurgery, genito-urinary & orthopedic surgery. Good salary & personnel policies. Apply: Director of Nursing, Victoria Hospital, London, Ontario.

Operating Room Staff Nurses for modern well equipped department, gross starting salary $255 per mo., rotating hours of duty. Apply to: The Director of Nursing, The Doctors Hospital, 45 Brunswick Ave., Toronto, Ontario.

QUEBEC

Assistant Head Nurses; Afternoon Supervisor excellent personnel policies. Apply Director, Shriners' Hospital for Crippled Children, 1529 Cedar Avenue, Montreal, Quebec.

Registered Nurses for modern 60-bed General Hospital, 40-mi. south of Montreal. Salary $260 per mo. in effect by February 1960, 5 semi-annual increases; monthly bonus for permanent evening & night shifts, 44-hr. wk., 4-wk. vacation. Board & accommodation available in new motel-style nurses' residence. Apply: Superintendent, Barrie Memorial Hospital, Ormstown, Quebec.

Registered Nurses & Trained Nursing Assistants for hospital specializing in Chest Diseases (in the Montreal area). Excellent personnel policies, working conditions & accommodation in the Nurses' Home. Reply to: Box 1000, Ste. Agathe des Monts, Quebec.

Registered General Duty Nurses for 28-bed General Hospital in Huntingdon, Quebec, 45-mi. from centre of Montreal with excellent bus service. Gross salary $235 with full maintenance in nurses' home at $35; 3 increases at 6-mo. intervals to $250; 44-hr. wk., 8-hr. rotating shifts; 1-mo. annual vacation; 7 statutory holidays: 2-wk. sick leave, Blue Cross paid. Apply: Mrs. D. Hawley, R.N., Huntingdon County Hospital, Huntingdon, Que.

BERMUDA

Chief Dietitian for 140-bed hospital. Training school affiliated with Montreal hospitals. Fare paid. For particulars write Matron, King Edward VII Memorial Hospital, Bermuda.

Registered Nurses for Operating Room with operating room postgraduate courses and/or experience, for 140-bed hospital. Travel allowance paid. For particulars, write Matron, King Edward VII Memorial Hospital, Bermuda.

SASKATCHEWAN

Supervisor (Teaching) to implement program for auxiliary personnel in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary $300 for Saskatchewan registration, $280 for non-Saskatchewan registration. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

Operating Room Supervisor for 177-bed hospital to commence duty January or February, 1960, in preparation for taking over the duties of Supervisor in May, 1960. Postgraduate in O.R. technique preferable but not essential. Good personnel policies. For full particulars please apply to: The Director of Nursing, Swift Current Union Hospital, Swift Current, Saskatchewan.

Registered Nurses (2) Certified Nursing Assistants. Salary $280-310 & $180-$210 respectively, 40-hr. wk., 1½-days sick leave per mo., 3-wk. paid vacation, transportation allowance, direct applications to: B. L. Ellis, Secretary, Union Hospital, Coronach, Saskatchewan.

Registered Nurses for new 18-bed hospital with new nurses' residence opening May 1960. We have 4 Doctors on our Medical Staff also Canadian Mental Health Services & Canadian Arthritis & Rheumatism Services. 30 days annual vacation, this includes statutory holidays. Starting salary $260 per mo. which shall be increased in January 1960. Apply: John Uhryn-Administrator, Union Hospital, Davidson, Saskatchewan.

Graduate Nurses for General Duty in accredited 144-bed hospital, 74-bed new wing recently opened. Gross salary effective January 1, 1960 $270 or $250 according to registration. 40-hr. wk., 3-wk. annual vacation, 8 statutory holidays, accumulative sick leave. Pension plan available. Apply to: Superintendent of Nurses, Victoria Union Hospital, Prince Albert, Saskatchewan.

U.S.A.

Registered Nurses for modern 191-bed JCAH fully accredited General Hospital, expanding to 374-beds by 1960. Located on beautiful San Francisco Peninsula, 20-min. drive from the heart of the city. Openings in all services. Excellent personnel policies. Many extra benefits & opportunities for advancement. Top salaries. Apply: Personnel Director, Peninsula Hospital, 1783 El Camino Real, Burlingame, California.

Registered Nurses (California) for progressive ultra-modern 200-bed hospital (near Beverly Hills), in medical surgical units & operating room. Starting salary $330 per mo. with 6-mo. increase & yearly increases thereafter; 5-day, 40-hr. wk., 8 paid holidays annually, paid vacation, paid sick leave, free hospitalization & life insurance, plus unemployment & disability insurance. Opportunities for advancement & in-service education program. Work in a friendly efficient atmosphere possessing many new time & effort saving devices. Off-duty time may be spent in the sun & social activities of "Southern California Living". Apply Director of Personnel, Mount Sinai Hospital, 8720 Beverly Blvd., Los Angeles 48, California.

Registered Nurses General Duty for 230-bed approved teaching hospital, resort city. Salary $330 plus $22.50 shift differential, provision for housing allowance. Apply: Director of Nursing, Cottage Hospital, Santa Barbara, California.

-- WANTED --

SUPERINTENDENT OF NURSING

DEPARTMENT OF HEALTH AND SOCIAL SERVICES
JORDAN MEMORIAL SANATORIUM
THE GLADES, N.B.

QUALIFICATIONS: Graduation from a recognized school of nursing, preferably postgraduate study in Tuberculosis Nursing and/or in nursing administration. Registration as a Nurse in the Province of New Brunswick or a province of Canada. Several years of supervisory nursing experience.

DUTIES: The duties of this class involve complex and administrative responsibility performed in directing the nursing and related services in a Tuberculosis hospital.

SALARY: $3,480 — $4,200 per annum; Annual Increment — $180. Salary commensurate with education and experience.

Full Civil Service benefits including three weeks' annual vacation with pay, sick leave benefits, superannuation and retiring leave. Other perquisites available.

APPLY: **CIVIL SERVICE COMMISSION**
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MONTREAL, QUEBEC

NURSING OPPORTUNITIES

Completion of expansion program makes available attractive positions for Registered Nurses in administration and general duty and also for Certified Nursing Assistants. Excellent personnel policies. Salary in accordance with the Association of Nurses of the Province of Quebec recommendations and commensurate with experience and education. Limited number of bursaries available for post-basic study after one year's service. Residence accommodation in very pleasant surroundings. Within 50 miles of Laurentian holiday and ski resorts. For further information, please write:

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General Duty Nurses for 100-bed County Hospital, accredited JCAH. San Joaquin Valley. 40-hr. wk., liberal sick leave, 3-wk. annual vacation, 12 annual holidays. Starting salary open, range $314-$392, plus $10 shift differential. Rooms in modern nurses' home at $10 per mo. Write, wire or phone: Superintendent of Nurses, County General Hospital, Tulare, California.

Staff Nurses 600-bed general & tuberculosis teaching institution in central valley City. Accredited State & Junior Colleges in immediate vicinity, liberal personnel policies. Full maintenance available. Write — Director of Nursing Service, Fresno County General Hospital, Fresno 2, California.

Staff Nurses (all departments) **Head Nurse positions** (several) Come to sunny California. 450-bed Queen of Angels Hospital, excellent working conditions, starting salary $330 for Staff Nurses — $380 for Head Nurses — plus PM & Night premiums — merits increase program, vacations, sick pay etc. Apply: Personnel Director, 2301 Bellevue Avenue, Los Angeles 26, California.

Staff Nurses for 300-bed General Hospital. Attractive personnel policies plus differential for specialties, afternoon & night duty. Opportunities for advanced education. Apply to: Director of Nursing Service, Kaiser Foundation Hospital, Oakland 11, California.

General Staff Nurses (Grow & develop with us) new 400-bed hospital under construction. Fully approved. Intern-resident program. Developing teaching center. Starting salary $330 per mo., $15 per mo. merit increases at 6, 12, 24 & 36-mo. 40-hr. wk., 2-wk. paid vacation, paid sick leave to 30 days; 7 paid holidays. One of Southern California's most outstanding locations. Apply: Director of Personnel, Seaside Memorial Hospital, 1401 Chestnut Avenue, Long Beach 13, California.

General Duty Nurses for 50-bed General Hospital located in college town in mountainous portion of Colorado. Salary $300 per mo. with periodic increases. Fringe benefits include meals, uniform laundry, sick leave & vacation. Registration requires 3-mo. training in Psychiatry & Pediatrics on a segregated service. Contact: Superintendent, Community Hospital, Alamosa, Colorado.

Registered General Duty Nurses for 154-bed General Hospital with expansion program under way. Along the shores of Lake Michigan, 25 mi. from Chicago. Salary: $365 for days, $395 for evenings, $385 for nights, 5 day wk. Good personnel policies. Apply Personnel Director, Highland Park Hospital Foundation, 718 Glenview Ave., Highland Park, Ill.

General Duty Nurses for 320-bed General Hospital. Only a few blocks from Lake Michigan Beach & Lincoln Park; near Chicago Loop. Hospital accredited by J.C.A.H. & school of nursing accredited by N.L.N. Apartments available close to hospital. Liberal personnel policies. Must be eligible for Ill. registration; openings on all shifts. Write: Director of Nursing, Augustana Hospital, 411 W. Dickens Ave., Chicago 14, Illinois.

Operating Room Nurses (Days & P.M.) 154-bed General Hospital located in beautiful residential suburb along the north shore of Lake Michigan just north of Chicago. Modern ranch style nurses' homes with attractively furnished private bedrooms. 40-hr. wk. Salary: $390 days, $420 evenings, other employee benefits. Contact: Personnel Director, Highland Park Hospital Foundation, Highland Park, Illinois.

Registered Nurses for fully accredited 291-bed hospital with all services, starting salary $330-$360 per mo., including ICU. Retirement plan paid, insurance & other fringe benefits. Write: Personnel Director, Washoe Medical Center, Reno, Nevada.

Registered Nurses (free transportation) Spend your winter in the Sunny Southwest, in New Mexico — "The Land of Enchantment". Vacancies for staff duty in Medicine, Surgery, Obstetrics, Pediatrics & Operating Room. Starting salaries $300 per mo., $15 differential evenings & nights. Free transportation via 1st Class Air to Albuquerque & return in exchange for 1-yr. employment contract. Apartment available at $17 per mo., excellent job benefits, no shift rotation. Write or call: Director of Nursing, Presbyterian Hospital Center, 1012 Gold Avenue, S.E., Albuquerque, New Mexico, Phone CHapel 3-5611.

Graduate Nurses (Staff & Operating Room) for 88-bed modern accredited General Hospital. Liberal personnel policies, college town 30,000, 85% sunshine belt, altitude 3 860. Dry, mild, all year climate. Apply: Director of Nurses, Memorial General Hospital, Las Cruces, New Mexico.

Registered Nurses (Scenic Oregon, vacation playground, skiing, swimming, boating & cultural events) for 295-bed teaching unit on campus of University of Oregon medical school. Salary to start: $339. Pay differential for nights & evenings. Liberal policy for advancement, vacations, sick leave, holidays. Apply: Multnomah Hospital, Portland 1, Oregon.

Staff Nurses (all services) for University of Texas Medical Branch, teaching hospital (air conditioned). Good personnel policies. Base salary, rotation: $290 per mo. Evenings or nights $304 per mo. Apply: Director Nursing Service, University of Texas Medical Branch, Galveston, Texas.

BRITISH COLUMBIA

Fully Trained Nurses (2) Trained Practical Nurses (2) for 60-bed United Church Mission Hospital in northern British Columbia. Opportunity for Christian service. Apply: Medical Superintendent, Wrinch Memorial Hospital, Hazelton, British Columbia.

THE WINNIPEG GENERAL HOSPITAL

is recruiting

GENERAL DUTY NURSES FOR ALL SERVICES

Please send applications direct to:

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THE WINNIPEG GENERAL HOSPITAL,
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Are you a
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Do you enjoy
Nursing
which brings you into
Closer Contact
with your
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and their families?

Are you interested in
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in a unique & useful sphere?

Have you also read the advertisement under Postgraduate Nursing Education?

Then write, giving particulars of your training, to:—

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QUEEN SQUARE,
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THE VANCOUVER GENERAL HOSPITAL

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PEDIATRIC, OPERATING ROOM & PSYCHIATRIC NURSES

General staff positions also available.

Salary: $280 - $336 general staff.

Commencing salary $294 for approved experience of 2-yrs.

Salary: Operating Room Nurses, $286.25 - $343.25.

A clinical differential of $10 a month in addition for approved postgraduate course.

4-week vacation per year.

Please apply to:

Personnel Department,
Vancouver General Hospital,
Vancouver 9,
British Columbia

"STOP! IS THIS WHAT YOU ARE LOOKING FOR?" Applications are invited for positions on the permanent or "vacation relief" Staff of a 50-bed active hospital 35-mi. from Vancouver. R.N.A.B.C. Personnel Policies in effect. Apply to Director of Nursing, Langley Memorial Hospital, Murrayville, British Columbia.

NEW BRUNSWICK

Clinical Instructor for 110-bed modern hospital. Personnel policies under revision to be effective in 1960. Apply: Superintendent, Charlotte County Hospital, St. Stephen, New Brunswick.

NEWFOUNDLAND

Laboratory Technician (1, Fully qualified) for 120-bed General Hospital. Salary according to Newfoundland Government scale. 1 way transportation paid. Customary vacation with pay after 12-mo. service plus all statutory holidays. Apply to: H. C. Vincent, Business Manager, Notre Dame Bay Memorial Hospital, Twillingate, Newfoundland.

ONTARIO

Director of Nursing for 222-bed hospital under construction in Burlington, Ontario. Position requires Graduate Nurse with extensive teaching, administrative & supervisory experience. This is a challenging post involving the organization & control of the entire nursing staff. Reply by January 31, giving complete qualifications, experience, salary expected & references to: Administrator, Joseph Brant Memorial Hospital, Burlington, Ontario.

Assistant Director of Nursing, Registered Nurses for General Duty for new hospital. Good salary, 21 days vacation, 8 statutory holidays, accommodation available in residence. Apply: Director of Nursing, Miss K. King, Ross Memorial Hospital, Lindsay, Ontario.

QUEBEC

Operating Room Nurses for modern well equipped department in 140-bed General Hospital. No rotation but required to take night calls. Good personnel policies & salary in accordance with A.N.P.Q. recommendations. Apply: Director of Nursing, Reddy Memorial Hospital, 4039 Tupper Street, Montreal, Quebec.

ALBERTA

General Duty Nurse for 17-bed hospital, 100-mi. north of Calgary, salary $265 gross with increments of $5.00 every 6-mo. for 3 increases, 44-hr. wk., 3-wk. vacation after 1-year of service, 10 statutory holidays, board & room $35 per mo. Apply: Municipal Hospital, Elnora, Alberta.

SASKATCHEWAN

Graduate Nurses (2) for 8-bed hospital in southern Saskatchewan. Starting salary $280 less $35 maintenance. 3-wk. vacation, plus statutory holidays, 40-hr. work week. Travel fare advanced if necessary. Apply to: Mrs. D. L. Knops, Secretary-Treasurer, Union Hospital, Rockglen, Saskatchewan.

U.S.A.

Staff Nurses for large modern tuberculosis hospital in suburban Cleveland. Nurses eligible for Ohio registration start at $355 per mo. with semi-annual increments. Extra pay for relief & night duty. Opportunities for advancement. Married nurses with families or two (2) single nurses may live in attractive, completely furnished 2-bedroom houses at low, low rent including utilities. 5-day wk., paid vacation & holidays. Liberal sick leave cumulative to 90-days. Retirement plan. Approved by Joint Committee on Accreditation of Hospitals. Write: Director of Nursing, Sunny Acres Hospital, Cleveland 22, Ohio.

Registered Nurses — Salary open, commensurate with experience, differential for evenings & night service. Openings in Obstetrical & Medical-Surgical areas. Must be eligible for registration in the State of Michigan. Apply to: Personnel Department, Woman's Hospital, 432 E. Hancock Avenue, Detroit 1, Michigan.

DIRECTOR -- PRENATAL CLASSES

To direct prenatal Classes and study program of the Prenatal Education Committee, sponsored by the Social Planning Council of Metropolitan Toronto.

Requirements: Registered Nurse, preferably with certificate in public health nursing; preparation and experience in administration and experience in the area of maternal and child care.

Salary: minimum $5,000. Starting salary commensurate with specific qualifications and experience.

Apply to:

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WOODSTOCK GENERAL HOSPITAL
Woodstock, Ontario

requires

Registered Nurses
for Operating Room, Obstetrical, Medical and Surgical units.

For further information write:

THE DIRECTOR OF NURSING,
GENERAL HOSPITAL,
WOODSTOCK, ONTARIO.

REGISTERED NURSES
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CERTIFIED NURSING ASSISTANTS
REQUIRED FOR

44-bed hospital with expansion program, 40-hr. wk. Situated in the Niagara Peninsula. Transportation assistance.

For salary rates & personnel policies
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MENTAL HEALTH SERVICES,
ESSONDALE, PROVINCE OF BRITISH COLUMBIA
Salary: $324 - $389 per month

Duties are those of nursing supervisors in modern psychiatric & geriatric units.

Applicants must be British Subjects, registered nurses, with training in a mental hospital setting & supervisory experience.

For further information & application forms, apply to:
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IMMEDIATELY. COMPETITION No. 59:152

PUBLIC HEALTH NURSE
(qualified)
for

City Health Department January 1, 1960 excellent working conditions, including pension plan, hospitalization benefits, etc.

APPLY TO:
MEDICAL OFFICER OF HEALTH,
CALGARY, ALBERTA.

REGISTERED NURSES
required for
MENTAL HEALTH SERVICES
B.C. CIVIL SERVICE

Starting salary $270-$292 per month depending upon experience, rising to $325 per month. Applicants must be Canadian citizens or British subjects and registered, or eligible for registration in British Columbia.

For application forms apply IMMEDIATELY to the:
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COMPETITION NO. 59:608

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Five Summer Camps
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GRADUATE NURSES AND NURSING ASSISTANTS

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TORONTO 2, ONTARIO.

GENERAL STAFF NURSES
WANTED

To begin January 1, 1960
Salary Reg. N. $265 gross
100-bed hospital

Write:

THE ADMINISTRATOR,
NORFOLK GENERAL HOSPITAL,
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UNIVERSITY HOSPITAL

SASKATOON, SASKATCHEWAN

Requires

General Staff Nurses for Medical, Surgical, Obstetrical and Pediatric Services. Forty hour week. Salary $270 to $310 gross per month. Differential for evening and night duty. Residence accommodation if desired.

Apply to:

DIRECTOR OF NURSING, UNIVERSITY HOSPITAL,
SASKATOON, SASKATCHEWAN

GRADUATE STAFF NURSES — YOU WILL LIKE IT HERE

Opportunities for men & women on the service of your choice. A 953-bed teaching hospital with a friendly atmosphere, well planned orientation program, active graduate nurse club, cultural advantages & excellent transportation facilities.

Starting salary: $325 per mo., 6 holidays, sick leave, 3 wk. vacation.

For further details write:

Director — Nursing Service, University Hospitals of Cleveland, Ohio.

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Indian and Northern Health Services

Requires

PUBLIC HEALTH NURSING SUPERVISORS
$4,620 - $5,160
(Competition No. 59-834)

DIRECTORS OF NURSING
$4,350 - $4,860
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$3,900 - $4,560
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Vacancies at various centres throughout Canada

For details, write to
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Please quote appropriate competition number.

REGISTERED NURSES
AND
CERTIFIED NURSING ASSISTANTS

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QUEEN MARY VETERANS HOSPITAL, MONTREAL
WESTMINSTER HOSPITAL, LONDON
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Pension plan; three weeks' paid vacation; three weeks' cumulative sick leave; 5 day week; low cost living in staff residence — for Nurses. Application forms are available at Civil Service Commission Offices, National Employment Offices and main Post Offices.

For further particulars contact the Civil Service Commission Office in the province where the position in which you are interested exists —

ONTARIO — 25 St. Clair Ave. East, Toronto
MANITOBA — 266 Graham Ave., Winnipeg
NEW BRUNSWICK — Post Office Bldg., Canterbury St., Saint John, N.B.
QUEBEC — 685 Cathcart St., Montreal

Residence, Cook County School of Nursing

NURSES WHO LIVE HERE NEVER STOP LEARNING . . . GROWING

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Here's an opportunity to gain unique and valuable experience in a *public* hospital — world's largest for acute medical conditions. Cook County Hospital offers you the stimulation of working with more than 2,500 other doctors and nurses in one of the world's largest and most exciting medical centers. Housing is available at nominal cost. Salaries begin at $340-$372.50 for a 37½ hour week. And you're only minutes from Chicago's fabulous Loop and local universities.

Graduate Nurses! Write today to Director, Cook County School of Nursing, Dept. C., 1900 West Polk Street, Chicago 12, Illinois.

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REGISTERED NURSES FOR IMMEDIATE EMPLOYMENT

- STARTING SALARIES $376 WITHOUT EXPERIENCE, $395 WITH ONE YEAR PSYCHIATRIC NURSING
- STIMULATING AND CHALLENGING CAREERS
- CHOICE OF LOCATION
- PROMOTIONAL OPPORTUNITIES
- REGULAR SALARY INCREASES
- LIBERAL EMPLOYEE BENEFITS

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Eligibility for California License
and
Possession U.S. Declaration of Intention Required

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Write Mrs. Katharine Steele

DIRECTOR OF NURSING SERVICES, DEPARTMENT OF MENTAL HYGIENE
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has Staff and Supervisory positions in various parts of Canada.

Personnel Practices Provide:

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For further information write to:

Director in Chief,
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GENERAL STAFF NURSES
required
The General Hospital of Port Arthur School of Nursing
Salary schedule in conformity with R.N.A.O. recommendations.
Partial fare refund after 1-yr. in service.

WRITE:
DIRECTOR OF NURSING,
GENERAL HOSPITAL OF PORT ARTHUR, PORT ARTHUR, ONTARIO.

GUELPH GENERAL HOSPITAL
REQUIRES
STAFF FOR THE FOLLOWING POSITIONS:

Assistant Head Nurses — General Wards (3), General Staff Nurses, Certified Nursing Assistants, Active Hospital 200-beds, Pleasant city 36,000 — 3 colleges. Excellent salary & personnel policies. Additional salary for postgraduate study in specialty.

For further information apply to:
DIRECTOR OF NURSES, GENERAL HOSPITAL, GUELPH, ONTARIO.

REGINA GENERAL HOSPITAL
REGINA, SASKATCHEWAN
invites
Applications for the Position of
DIRECTOR OF NURSING

800-bed, fully accredited General Hospital with large School of Nursing embarking on a two year teaching, plus one year interne, student nursing course effective September 1960. Organization provides Associate Directors in Nursing Service and Nursing Education.
Benefits cover Pension Plan, Group Life Insurance, sick leave, four weeks vacation. Living accommodation available if desired.

Inquiries and applications to be forwarded to:
MR. C. E. BARTON, EXECUTIVE DIRECTOR

The Roosevelt Hospital

428 WEST 59th STREET • NEW YORK 19, N.Y.

APPLICATION FOR APPOINTMENT
NURSING SERVICE DEPARTMENT

NAME (PRINT) .....

ADDRESS .....

.....

BIRTHDAY ..... MARITAL STATUS .....

WHERE REGISTERED .....

POSITION SOUGHT .....

DATE AVAILABLE .....

PROFESSIONAL BACKGROUND

BASIC NURSING & POSTGRADUATE COURSES	ADDRESS	DATE OF DIPLOMA OR DEGREE

EXPERIENCE (LIST MOST RECENT POSITION FIRST)

POSITION	HOSPITAL AND LOCATION	DATE

TRANSPORTATION FROM CANADA PAID UPON APPOINTMENT TO STAFF

COMMENTS:

PLEASE INDICATE IN NUMERICAL ORDER, NURSING SERVICE PREFERRED:

☐ MEDICINE ☐ MEDICINE & SURGERY ☐ PEDIATRICS
☐ SURGERY ☐ OPERATING ROOM ☐ GYNECOLOGY

SEND TO: DIRECTOR, NURSING SERVICE
THE ROOSEVELT HOSPITAL
428 WEST, 59th STREET
NEW YORK 19, NEW YORK